Department of Defense
INSTRUCTION

March 10, 1993
NUMBER 6010.15

ASD(HA)

SUBJECT: Third Party Collection (TPC) Program

References: (a) DoD Instruction 6010.15 subject as above March 7, 1991 (hereby canceled)
(b) Title 10, United States Code, Sections 1075, 1076, 1078 and 1095
(c) Title 32, Code of Federal Regulations, Part 220, "Collection from Third Party Payers of Reasonable Hospital Costs, current edition"
(d) DoD 7220.9-M, "Department of Defense Accounting Manual," October 1983, as authorized by DoD Instruction 7220.9, October 22, 1981
(e) through (j), see enclosure 1

A. REISSUANCE AND PURPOSE

This Instruction:

1. Reissues reference (a).

2. Updates policy, responsibilities, and procedures to implement an aggressive TPC Program at military hospitals that will result in additional revenues to support the provision of enhanced health care services to DoD beneficiaries.

B. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense and the Military Departments.

C. DEFINITIONS

Terms used in this Instruction are defined in enclosure 2.

D. POLICY

It is DoD policy:

1. To collect from third party payers to the fullest extent allowed by law. A third party payer has an obligation to pay the United States the reasonable costs of health care services provided in any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the third party payer's plan. The obligation is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third party payer if the beneficiary

were to incur the costs on the beneficiary's own behalf. Authority to collect from third party payers has been expanded to include outpatient services, automobile liability and no-fault insurance and Medicare supplemental insurance carriers.

2. All funds collected under 10 U.S.C. 1095 [reference (b)] from a third party payer for the costs of health care services provided at a Uniformed Service facility shall be credited to the appropriation supporting the operation and maintenance of that facility. Health care services include both inpatient and outpatient health care as well as the provision of ancillary services. To provide a strong incentive to ensure a high priority on the TPC program at the facility level all funds collected on or after October 1, 1989 through the TPC program shall be deposited into the appropriation supporting the MTF in the fiscal year in which collections are made, and to the extent practical shall be available to the local military treatment facility rendering the care. Collections shall be over and above the hospital's direct budget authority in the year of execution as obtained through the normal budget process.

3. All funds collected under the TPC program, except for amounts used to finance collection activities, shall be used to enhance health care services.

4. A decision on whether or not to admit a beneficiary for hospital care shall not be influenced by whether or not the beneficiary is covered by a third party payer. Current policies that base admission on such factors as the medical needs of the patient and the availability of needed facilities and personnel shall remain in effect.

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) shall:

a. Issue policy guidance and provide oversight to ensure that the TPC program is resulting in maximum collections.

b. Develop and issue to the Services collection goals and evaluate the Service's performance toward meeting those collection goals.

c. Develop a training program that addresses all aspects of accounts receivable management, utilization management, and medical records administration as they apply to the TPC Program.

d. Ensure that all management information and similar support systems necessary for the TPC Program are available and operational.

e. Establish an issues resolution process by which recommendations can be systematically evaluated by TPC program managers.

2. The Secretaries of the Military Departments shall:

a. Ensure that TPC Program policies and directions are implemented and fully executed.

b. Actively participate with the office of the Assistant Secretary of Defense (Health Affairs) in the development of a comprehensive TPC Program Implementation Plan that provides guidance to MTFs on all aspects of the program.

c. Distribute Service collection goals among the MTFs in a manner which considers unique facility attributes of the MTF including population and demographic differences.

d. Participate in the development of an ongoing training program and ensure full resourcing of the training requirement.

e. Develop and implement awareness programs for top Service managers and training and education programs for activity level personnel.

f. Develop a training module that incorporates Service-unique aspects that will enhance the identification and subsequent billing of insurance candidates.

g. If appropriate, compromise, settle, or waive a DoD claim under this Instruction.

h. Provide any support necessary for implementing the TPC Program, ensuring that adequate resources are devoted, personnel are fully trained, and support systems are functional.

i. Provide consolidated and MTF level versions of the reports specified in subsection F.5 below.

j. Utilize the Issues Resolution Process when requesting policy determination on recommendations or concerns and publicize the issue resolution procedures whereby recommendations or concerns receive high level review and evaluation.

3. Each Commander of a Military Medical Treatment Facility (MTF) shall:

a. Aggressively implement a TPC Program, and shall provide adequate resources, leadership, training, and support.

b. Designate an office to be responsible for TPC Program operations.

c. Follow all procedures delineated in section F below, and by the Military Departments.

d. Ensure that all revenues collected are used appropriately according to the policies specified in section D above.

e. Maintain an audit trail of how program collections are spent, documenting amounts spent for program operations and health care services.

f. Submit periodic reports on the activity's TPC Program results as specified by subsection F.5 below.

g. Utilize the Issues Resolution Process when requesting policy determination on recommendations.

F. PROCEDURES

1. Establish a TPC Program

a. The TPC Program requires reviewing all aspects of accounts receivable management and necessitates the participation of many functions within the MTF including physician and nursing staffs, admissions, medical records, utilization and quality assurance review, ancillary departments, management information, as well as the finance offices. Activities must establish a TPC Program that, at the very least, identifies those Uniformed Services beneficiaries with third party payer plan coverage, complies with third party payer requirements, submits all claims to third party payers, follows up to ensure that collections are made, and documents and reports collection activities. The TPC Program procedures shall conform with third party payers' obligations under 32 CFR 220, [reference (c)].

b. Authority to collect applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after April 7, 1986, for inpatient hospital care provided after September 30, 1986. Authority to collect also applies to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after November 5, 1990 for Medicare supplemental plans, automobile liability and no-fault insurance plans, and outpatient care provided after November 5, 1990. An amendment includes, but is not limited to, any change of rates, changes in benefits, changes in carriers, and conversions from insured plans to self-insured plans or the reverse.

c. DoD MTFs should not enter into participation agreements with payers because such participation agreements are premised on compliance with State and local laws, and Federal entities are governed by Federal statutes and regulations. MTFs may reach understandings with third party payers on claims procedures and other administrative matters if such understandings do not claim to be preconditions to complying with State and local statutory and regulatory requirements.

d. Implementation of outpatient collections prior to distribution of a standard system may not be cost effective at some locations. MTFs shall implement an outpatient collection program unless analysis demonstrates that it would not be cost

effective to implement the program on an interim basis. MTFs shall follow the procedures prescribed in enclosure 3, Outpatient Cost Benefit Analysis Methodology, in conducting a business analysis. Perform the cost benefit analysis for a one year period using calendar year 1993. Procurement of hardware to support the outpatient collections program shall not exceed the configuration determined in the cost benefit analysis without the approval of the Service.

2. Health Insurance Information Gathering

a. Certification of insurance coverage shall be made by each beneficiary on the occasion of each admission or visit to a MTF. Written certification shall be obtained from beneficiaries at the time of each inpatient admission or at the time of an outpatient visit if written certification is not in the patient medical record or has not been updated within the past 12 months. Annually, after 12 months have passed from the date of original signature on file, the patient must update and sign a new form on their first visit or admission in each 12-month period. During the certification, MTF staff personnel are to question each Uniformed Services beneficiary on the presence or absence of health insurance coverage and for those with coverage, verify or obtain the insurance company name, and policy identification information. Enter insurance information obtained during the admission or visit, including negative responses, on DD Form 2569, "Third Party Collection Program - Insurance Information" (enclosure 4). The original signed DD Form 2569 should be present in the outpatient record, a copy should be kept in the inpatient record. Follow-up verification that the beneficiary does not have insurance coverage may be recorded by an endorsement on the DD 2569 or an entry on the treatment record until the 12-month expiration date is reached.

b. For those inpatient and outpatient beneficiaries who indicate that they do not have health insurance coverage, retain the original of the signed form in the outpatient medical record. Place a copy of the signed DD Form 2569 in the inpatient medical record.

c. For those patients who indicate that they do have health insurance coverage, insert the original of the signed form in the outpatient medical record, a copy of the form in the inpatient medical record, and forward a copy of the signed form to the appropriate billing office. The exterior of both the inpatient and outpatient medical records may be flagged in an appropriate manner to indicate that the beneficiary has third party payer coverage.

d. Third party payers may require compliance with utilization review (UR) mechanisms in effect for other policy holders. UR mechanisms may include pre-admission certification programs, second surgical opinion requirements, and concurrent reviews of admission or continued stay, etc. To the extent

practicable, MTFs shall compile information on UR requirements of major local insurance policies and establish mechanisms to effect compliance with any such UR requirements allowed under 32 CFR 220 [reference (c)].

3. Billing Activities

a. Financial accounting for billings, collections, and the disposition of third party collections shall be as prescribed in DoD 7220.9-M [reference (d)].

b. The subordinate medical facility that issues third party billings shall establish and maintain memorandum accounting records as required by the parent organization that can report:

(1) The action taken on each claim.
(2) The amount billed.
(3) The amount collected.
(4) The amount resolved as invalid billings.
(5) The delinquent amount.
(6) The final account disposition.
(7) How the total collections were spent in accordance with subsection D.3 above.

c. Accurately prepare and submit claims to third party payers. The MTF shall use the DD Form 2502, "Uniform Billing for Inpatient Hospital Costs" until supplies of the form are depleted, to prepare bills to third party payers for both inpatient and outpatient medical care and services rendered to dependents and retirees. Once depleted, the MTFs will utilize commercial forms such as the UB82, UB92, or the HCFA 1500. Local situations could require using a form other than the DD Form 2502 to bill some third party payers. To the extent practical, MTFs shall comply with the data elements and code specifications of the National Uniform Billing Committee and the Uniform Claim Forms Task Force for submitting bills to third party payers. Billings shall be prepared and forwarded to the third party payer within 15 days following dictation of the medical record but in no instance greater than 30 days following the patient's discharge from the MTF. In situations involving long term hospitalization of beneficiaries, interim billings shall be made on a periodic basis, not to exceed 90 day intervals.

d. The per diem or per visit charge equal to the applicable inpatient or outpatient reimbursement rate subdivided into hospital, physician, and ancillary charges shall be used as an interim step to bill third party payers until such time as patient-level rates associated with a medical specialty, diagnosis related group, ambulatory patient group or other methods are developed and implemented. The Office of the Comptroller of the Department of Defense (OC, DoD) in coordination with the Assistant Secretary of Defense (Health Affairs) establishes the rates and the methodology that shall be used for billing third party payers. Rates shall be reviewed and

revised each fiscal year as appropriate. MTFs are not authorized to establish rates. Recommendations for additional rates can be accomplished through the issue process discussed in section F.6. Enclosure 5 contains several tables to assist MTFs with billing and reporting. These tables are described in section F.5. The Insurance Billing Requirements table clarifies the requirement to bill by patient category and by type of insurance policy. The Type Insurance and Report Preparations table clarifies which insurance type is included in each of the DoD reports. The Report by Patient table provides guidance on balancing insurance information by patient category among the various reports. Table 4, Reconciliation Among Reports, provides detailed information to assist balancing the DoD reports. The Fiscal Year Identity by Form (Table 5) specifies the reconciliation of fiscal year data among the DoD reports.

e. For inpatient hospital care provided before October 1, 1992, the computation of costs shall be based on the unified per diem full reimbursement rate for all clinical categories of hospital care. For purposes of this paragraph (and paragraph F.3.f, below) charges for patients hospitalized on and after the October 1 start date shall be based on the determination method in effect for the respective periods of hospitalization.

f. Rates for inpatient hospital care shall be published by the DoD Comptroller. Charges shall be based on the per diem full reimbursement rate applicable to the clinical category of services involved for inpatient hospital care provided on or after October 1, 1992. Patients treated in an intensive care unit any time during the 24-hour nursing period shall be charged the intensive care per diem charge for that day, instead of a charge to the clinical service to which the patient is currently assigned. Should the patient be assigned to more than one intensive care unit during the hospital day, the higher rate shall prevail. For patients assigned to more than one non-intensive care unit during the hospital day, the location of the patient at the hour of census taking shall determine the clinical group for reimbursement. For this purpose, the clinical groups are as follows:

(1) Medical Care Services. This includes internal medicine, cardiology, dermatology, endocrinology, gastro-enterology, hematology, nephrology, neurology, oncology, pulmonary and upper respiratory disease, rheumatology, physical medicine, clinical immunology, HIV III - Acquired Immune Deficiency Syndrome (AIDS), infectious disease, allergy, and medical care not elsewhere classified.

(2) Surgical Care Services. This includes general surgery, cardiovascular and thoracic surgery, neurosurgery, ophthalmology, oral surgery, otolaryngology, pediatric surgery, plastic surgery, proctology, urology, peripheral vascular surgery, and surgical care not elsewhere classified.

(3) Obstetrical and Gynecological Care.

(4) Pediatric Care. This includes pediatrics, nursery, adolescent pediatrics, and pediatric care not elsewhere classified.

(5) Orthopedic Care. This includes orthopedics, podiatry, and hand surgery.

(6) Psychiatric Care and Substance Abuse Rehabilitation.

(7) Family Practice Care.

(8) Burn Unit Care.

(9) Medical Intensive Care and/or Coronary Care.

(10) Surgical Intensive Care.

(11) Neonatal Intensive Care.

(12) Organ and Bone Marrow Transplants.

(13) Same Day Surgery.

g. As authorized by 10 U.S.C. 1095(f)(2), [reference (b)], the computation of costs for collections for most outpatient services shall be based on an all-inclusive per visit rate. The per visit charge shall be equal to the outpatient full reimbursement rate and includes all routine ancillary services provided within the MTF. A separate charge will be calculated for cases that are considered same day and/or ambulatory surgeries. Per visit and same day and/or ambulatory surgery rates shall be updated and published annually by the DoD Comptroller.

h. When a facility of the Uniformed Services purchases ancillary services or procedures from a source other than a Uniformed Services facility, the cost of the purchased services shall be added to the per diem or per visit rate. Examples of ancillary services and other procedures covered by this special rule include (but are not limited to): laboratory, radiology, pharmacy, pulmonary function, cardiac catheterization, hemodialysis, hyperbaric medicine, electrocardiography, electroencephalography, electroneuromyography, pulmonary function, inhalation and respiratory therapy, and physical therapy services.

i. If a Uniformed Services facility provides certain high cost ancillary services, prescription drugs, or other procedures based on a request from a source other than a Uniformed Services facility and not incident to an outpatient

visit or inpatient service at the MTF, the charge will not be based on the usual per visit or per diem rate. Rather, a separate standard rate shall be charged to recover the cost of the particular high-cost service, drug, or procedure provided. This special rule applies only to services, drugs, or procedures having a cost of at least $100. The cost for the services, drugs, or procedures to which this special rule applies shall be calculated and published annually by the DoD Comptroller.

j. The Uniformed Services maintain certain contract clinics called PRIMUS (Primary Care for the Uniformed Services) clinics by the Army and Air Force, and NAVCARE (Navy Cares) clinics by the Navy. These are outpatient clinics that provide only primary care services. Services provided by these clinics are paid for by a facility of the Uniformed Service, of which the PRIMUS or NAVCARE clinic is considered operationally to be an extension. A separate, uniform per visit charge, representing the average cost to the Department of Defense for a visit in all PRIMUS and NAVCARE clinics shall be the basis of the charge for these clinics. This rate shall be calculated and published annually by the DoD Comptroller. Collections for PRIMUS/NAVCARE visits shall be used to offset the cost of the contracts or to increase the volume of services purchased.

k. In connection with Uniform Services Treatment Facilities, the computation of costs for collections may differ. Charges for such facilities shall be determined by the Department of Defense based on government charges for similar services under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

l. When a civilian physician provides health care services in a military MTF under the Military Civilian Health Services Partnership Program, DoD Instruction 6010.12 [reference (e)], for insured dependents and retirees, the military MTF shall bill the third party payer for the total per diem charge but adjust the bill to credit the professional component. The net charge shall be for the hospital and ancillary services components only. The civilian physician bears the responsibility for separately billing either CHAMPUS or the third party payer as appropriate in accordance with references (e) and (f).

m. Any third party payer that can demonstrate, under 32 CFR 220 [reference (c)], that its prevailing rates of payment in the same geographic area for the same or similar aggregate groups of services is less than the per diem or per visit rate (or other amount as determined under paragraphs F.3.e through j, above), may reimburse the Department of Defense at that prevailing rate for that aggregate category of service. MTFs should expect third party payers to provide documentation of the analysis which supports their contention that their prevailing rates are lower. When evaluating a position of a third party payer, MTFs are reminded that the comparisons must be made for similar specialty groups. If a payer normally pays on a DRG basis, all DRGs which

commonly fall within the category being questioned must be included in the payer's analysis. For example, if a payer questioned the internal medicine rate, all DRGs commonly falling in the internal medicine specialty category identified by the MEPRS category must be considered in the analysis. Documentation should include sample size, sample area, sample selection, grouping methodology, group mean, group standard deviation, confidence interval, and other factors deemed relevant. The burden of proof rests with the third party payer. Absence of such proof, full reimbursement shall be expected.

n. For insured dependents and retirees, charges for medical service and subsistence charges as required under 10 U.S.C. 1075 and 1078 [reference (b)] shall be considered to be included in the insurance coverage. No such charges may be collected from insured individuals, unless a claim has been resolved and no payment is received or expected from the third party payer.

o. A Military Health Service System beneficiary shall not be required to pay the MTF any deductible or co-payment amounts imposed by the third party payer. A beneficiary is any person determined to be eligible for benefits and authorized treatment in a military MTF, covered by Title 10 USC 1076(a) and 1076(b).

p. Health Maintenance Organization plans are subject to the Third Party Collection Program and shall be billed, and are expected to pay, for care to the same extent that they generally pay for services provided by other health care facilities not affiliated with the HMO.

q. Separate claims shall be made for the mother and for the baby in an inpatient delivery case.

r. Multiple outpatient visits on the same day to different clinics shall result in one charge for each clinic visit. Multiple visits on the same day to the same clinic shall result in only one charge.

s. Any payment made by the third party to the patient should not be considered as constituting payment under the TPC Program. The claim must be paid to the MTF. The MTF has no responsibility, and should not attempt, to collect from a patient any amounts erroneously paid to them by a third party payer.

t. MTFs shall make available on request to representatives of third party payers appropriate health care records of the patients for whom insurance payment is sought. The records that shall be made available are those necessary to verify that the services were provided and that permissible terms and conditions of the plan were met. Authorization for release of medical records by the patient is not necessary and is not dependent on the diagnosis except in the case of alcohol and/or

drug abuse, AIDS, and sickle cell cases. Patients shall be notified at the time that insurance information is collected that medical information relevant to an episode of care being billed will be provided to third party payers if requested.

u. Medicare supplemental carriers are statutorily required to accept the claim as one involving Medicare-covered services and cannot deny the claim on the grounds that no claim had previously been submitted by the provider or beneficiary for payment under the Medicare program. The obligation of a Medicare supplemental plan to pay shall be determined as if the facility of the Uniformed Services were a Medicare-eligible provider and the services provided as if they were Medicare-covered services. In general, Medicare supplemental plans are responsible for amounts comparable to beneficiary out-of-pocket costs under normal operation of the Medicare program. We are deferring any efforts to collect from Medicare supplemental policies for covered services, with the exception of inpatient hospital deductible amounts. The obligation to pay the inpatient deductible amount, which in 1993 is $676, only applies to policies which cover the inpatient deductible. The supplemental insurer will not be obliged to pay the MTF if the benefit is required to satisfy a patient's inpatient deductible in a civilian hospital arising from an admission within the same benefit period. If the benefit has already been paid to a facility of the Uniformed Services, it will be refunded to permit the benefit to be paid to the civilian hospital. This will assure that double payment from the insurer will not occur and that beneficiaries will not be left without insurance coverage for an out-of-pocket expense in connection with the inpatient deductible.

Inpatient example - In 1993 the inpatient deductible amount is set at $676. If the patient's total inpatient charges were $2,100 the supplemental plan would be liable for $676. Only one inpatient deductible charge shall be made per hospital admission, except in the case of an admission that occurs within 60 days of the discharge from a prior admission, no second deductible charge shall be made.

v. Third party collection authority has been expanded to include automobile liability and no-fault insurance policies. Authority to collect has also been extended to active duty members in these instances. MTFs shall submit all cases involving motor vehicle accidents to the servicing Judge Advocate General (JAG) office for review and collection. The MTF and the JAG shall work out an arrangement to ensure that the MTF is kept informed of which cases will be pursued by the JAG and which will not. Should the JAG official determine that tort liability should be the basis for recovery, substantive standards of the Federal Medical Care Recovery Act [reference (f)] shall apply. Collection shall be accomplished by the JAG unless collection authority is delegated by JAG to the MTF on a case-by-case basis.

Such cases are under 32 CFR part 220, section 1095 [reference (c)], and this Instruction. Should the JAG determine that the case falls within the purview of the State no-fault statute, the basis for recovery shall be the TPC Program. In either case, in accordance with subsections D.2 and 3, above, any monies collected shall be deposited to the referring MTF. Whether based on tort liability or no-fault authority, collection efforts will be handled by the JAG unless subsequently delegated to the MTF.

4. Follow-up Activities

a. For each claim in which the third party response is unsatisfactory (inappropriate denial or partial denial, inadequate payment amount, non-response, etc.), sufficient follow-up activities must be conducted and documented. Those follow-up activities include telephone contacts, letters, and any other steps that might result in satisfactory resolution. MTFs shall follow the specific debt collection procedures prescribed by their Service.

b. All claims shall be closed or forwarded from the MTF for formal debt collection and/or delinquent account action within 6 months of initial billing, but not in excess of 9 months from the date of discharge or outpatient care, unless there is clear evidence that a satisfactory resolution is expected within a reasonable time frame. Documentation of such expectation shall be made into the patient's accounts receivable record.

c. When payable claims are deemed delinquent, the procedures defined by DoD Directive 7045.13, [reference (g)] and DoD Instruction 7045.18, [reference (h)] shall be followed. Those procedures are under the policy direction of the Comptroller of the Department of Defense.

d. For cases in which TPC Program billings were made before the full implementation of this Instruction, and claims are unresolved, the MTF shall bring each case to a resolution in accordance with subsection F.4.

e. Collection for outpatient visits is effective as of October 1, 1992. Should the outpatient program be implemented after this date, MTFs are authorized to back bill until October 1, 1992 if they determine that back billing of outpatient visits is cost-effective.

5. Reporting Requirements

a. Enclosure 6 contains several tables to assist MTFs with report preparation. Table 2, Type Insurance & Report Source, indicates the inclusions of various insurance types on the required reports. Table 3, Reporting of Patient Category by Form, clarifies the reporting of charges by patient category. Table 4, Reconciliation Among Reports and Additional

Reconciliations, provide tips for reconciling the information on the various reports. The reporting of billing information by fiscal year is presented in Table 5.

b. Four quarterly reports shall be submitted to the ASD(HA) with information specified in enclosures 7, 8, 9, and 10. The Report on Program Results, the Collection Source Analysis, and the Insurance Type Report each include an inpatient and outpatient portion. The Aging Schedule reflects the sum totals of both inpatient and outpatient outstanding collections. The reports are due 30 days after the end of each quarter. Descriptions of the reports are provided in subsections (1) through (4) below. Copies of the forms and detailed instructions for their completion are provided as enclosures 7, 8, 9, and 10. MTFs shall submit both a hard copy and an electronic data file to their respective Service for consolidation and submission to the ASD(HA). Each quarter, the Services shall submit both a consolidated hard copy and an electronic data file and shall also submit a merged data file containing MTF detail data to include all fields covered on the quarterly reports. Submission of outpatient reports is required when either an automated version of the reports is included within standard supporting software or the MTF begins collection for outpatient care, whichever occurs earlier.

(1) Third Party Collection Program - Report on Program Results (DD Form 2570). This report summarizes only the non-active duty inpatient and outpatient billing and collection activity for the MTF. It excludes active duty and third party liability. Separate forms shall be completed for inpatients and outpatients to report the respective billing and collection activity. The Services shall consolidate each of the two reports for their MTFs and submit them to the ASD(HA) along with the individual reports for each MTF. The FY identity of each collection shall be maintained and shall be based on the date that medical services are rendered. Inpatient stays that span two FYs shall be reported for the FY in which the patient is discharged. For instance, care rendered that crosses from FY 1992 into FY 1993 shall always be reported as a FY 1993 claim. Collections shall be deposited to the operations and maintenance appropriation of the activity in the year in which collected, regardless of the year the care was rendered. For example, collection of a claim for care rendered in FY 1992 that is collected in FY 1993 would be reported as a collection made in the current year (FY 1993) for a claim that originated in Prior Year One (PY1) (FY 1992). Detailed instructions for completion of the DD Form 2570, for both inpatients and outpatients, are provided in enclosure 7.

(2) Third Party Collection Program - Aging Schedule (DD Form 2571). This report provides an indication of how aggressively activities are pursuing reimbursement from third

party payers and identifies the extent to which the payers are delinquent. Inpatient and outpatient open claims data shall be combined into a single aging report. A consolidated report shall be prepared by each Service and submitted to the ASD(HA) along with the individual report from each MTF. The total amount reported as uncollected for each FY on the DD Form 2571 shall reconcile to the total amounts remaining uncollected (Part I, block 4, column 11) as reported for that FY on both the inpatient and outpatient version of DD Form 2570. Detailed instructions for completion of the consolidated DD Form 2571 are provided in enclosure 8.

(3) Third Party Collection Program - Collection Source Analysis (DD Form 2607). This report summarizes for the current fiscal year only, the inpatient and outpatient source of collection activity at the MTF, excluding active duty and third party liability. Each Service shall consolidate the report and submit it to the ASD(HA) along with the individual reports for each MTF. Inpatient stays that span two FYs shall be reported for the FY in which the patient was discharged. For instance, care rendered in FY 1992 shall always be reported as a FY 1992 claim regardless of the year collection is made. Detailed instructions for completion of the DD Form 2607 for both inpatients and outpatients are provided in enclosure 9. An exemption to the requirement to submit this report for outpatient care may be granted by the Services if no automated report capability is available at an MTF.

(4) Third Party Collection Program - Insurance Type Report (DD Form 2608). This report summarizes billing and collection activity by the type of insurance (for example, no-fault/auto liability insurance, medical health care insurance, Medicare supplemental insurance, and other insurance) that is carried by the different patient categories. Inpatient and outpatient collections shall be reported separately in order to present a picture of the respective billing and collection activity. Each Service shall consolidate each of the two parts and submit them to the ASD(HA) along with the individual reports for each MTF. The FY identity of each claim shall be maintained and shall be based on the date that medical services are rendered. Detailed instructions for completion of the DD Form 2608 for both inpatients and outpatients, are provided in enclosure 10.

c. Each MTF shall submit to the ASD(HA), via their respective Service, an annual report as to how the amount of funds collected under the TPC Program were spent by the activity. It is only necessary that the MTF report how amounts collected under the auspices of the TPC Program were used. It is not necessary that the MTF attempt to track specific funds collected for the TPC Program through the accounting systems to the point of expenditure. A letter report is due to the ASD(HA) within 90

days of the end of each FY. No specific format for the letter report is specified.

6. TPC Issue Process

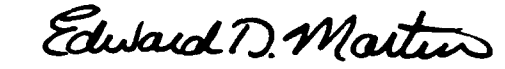
The people conducting the day-to-day business of talking with beneficiaries, gathering other health insurance information, billing third party payers, resolving disputes, etc., are likely to be the first to recognize the need for improvements in policy decisions or automation. A formal issues process will ensure uniformity of handling recommendations and that new ideas achieve visibility and consideration. MTFs will follow the procedures outlined in enclosure 11 whenever a request for a policy decision is made to the Service or DoD TPC program managers.

G. INFORMATION REQUIREMENTS

The quarterly and annual reporting requirements listed in this Instruction have been assigned Report Control Symbols DD-HA(Q)1854, DD-HA(Q)1855, DD-HA(A)1856, DD-HA(Q)1905, and DD-HA(Q)1906.

H. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.



Edward D. Martin, M.D.
Acting Assistant Secretary of Defense

Enclosures - 11

1. References
2. Definitions
3. Outpatient Cost Benefit Analysis Methodology
4. Instructions for Completing Form DD 2569, "Third Party Collection Program - Insurance Information"
5. Insurance Billing Requirements Quick Reference Tables
6. Tips for Reconciliation of Reports
7. Instructions for Completing Form DD 2570, "Third Party Collection Program - Report on Program Results"
8. Instructions for Completing Form DD 2571, "Third Party Collection Program - Aging Schedule"
9. Instructions for Completing Form DD 2607, "Third Party Collection Program - Collection Source Analysis - Section I and II"
10. Instructions for Completing Form DD 2608, "Third Party Collection Program - Insurance Type Report - Section I and II"
11. TPC Issue Process

REFERENCES, continued

(e) DoD Instruction 6010.12, "Military Civilian Health Services Partnership Program," October 22, 1987

(f) Public Law 87-693, "Federal Medical Care Recovery Act," September 25, 1962

(g) DoD Directive 7045.13, "DoD Credit Management and Debt Collection Program," October 31, 1986

(h) DoD Instruction 7045.18, "Collection of Indebtedness Due the United States," March 13, 1985

(i) Title 32, Code of Federal Regulations, Part 199, "Civilian Health and Medical Program of the Uniformed Services"

(j) Public Law 97-99, "Military Instruction Act," Section 911, December 23, 1981

DEFINITIONS

1. Automobile Liability Insurance. Insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(a) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries.

(b) Uninsured and underinsured coverage, in which there is a third party individual (tortfeasor) who caused the injuries but the medical expenses are covered by the patient's insurance because the tortfeasor is uninsured or underinsured.

2. CHAMPUS Supplemental Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under CHAMPUS. (For information concerning CHAMPUS, see CFR Part 199 (reference (i)).) The term has the same meaning as in Section 199.2 of reference (i). No insurance, medical service, or health plan provided by an employer or employer group may qualify as a CHAMPUS supplemental plan.

3. Facility of the Uniformed Services. Any MTF or dental treatment facility of the Uniformed Services (as that term is defined in 10 U.S.C. 101(43) reference (b)). Contract facilities such as Navy NAVCARE clinics and Army and Air Force PRIMUS clinics that are funded by a facility of the Uniformed Services are considered to operate as an extension of the local MTF and are included within the scope of this program. Facilities of the Uniformed Services also include several former Public Health Services facilities that are deemed to be facilities of the Uniformed Services under Section 911 of Pub. Law 97-99 (reference (j)) (often referred to as "Uniformed Services Treatment Facilities" or "USTFs").

4. Healthcare Services. Include inpatient, outpatient, and designated high-cost ancillary services.

5. Inpatient Hospital Care. Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment or observation) to a bed in a facility of the Uniformed Services that has authorized beds for inpatient medical or dental care. Infants born to either active duty Service members who have personal health insurance coverage or who are covered by a spouse's plan fall within the TPC Program and the third party payer should be billed. (Inpatient hospital care provided in the former Public Health Service Hospitals now deemed to be USTFs is not governed by this Instruction. Although USTFs are covered by 10 U.S.C 1095 (reference (b)), procedures for USTFs are separately established.)

6. Insurance, Medical Service, or Health Plan. Any plan or program designed to provide compensation or coverage for expenses incurred by a beneficiary for health or medical services and supplies. It includes:

(a) Plans or programs offered by insurers, corporations, organized healthcare groups or other entities.

(b) Plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

(c) Medicare supplemental insurance plans.

7. Medicare Supplemental Insurance Plan. An insurance, medical service, or health plan exclusively for supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" under Medicare program regulations.

8. No-Fault Insurance. An insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

9. Outpatient Hospital Care. Visits to a separately organized clinic or specialty service made by patients who are not currently admitted to the reporting MTF. Patient receives healthcare services for an actual or potential disease, injury, or life style-related problem.

10. Third Party Payer. An entity that provides an insurance, medical service, or health plan by contract or agreement. A third party payer includes:

(a) State and local governments that provide such plans.

(b) Insurance underwriters and private employers (or employer groups) offering self-insured or partially self-insured and/or partially underwritten health insurance plans.

(c) Automobile liability insurance and no-fault insurance carriers. It also includes Medicare supplemental insurance policies.

11. Third Party Payer Plan. Any plan provided by a third party payer, but not an income supplemental plan or workers compensation plan.

12. Uniformed Services Beneficiary. Any person who is covered by 10 U.S.C. 1074(b), 1076(a), or 1076(b) (reference (b)). For purposes of paragraph F.3 [illegible], above (but not for other sections), a Uniformed Services beneficiary also includes active duty members of the Uniformed Services.

OUTPATIENT COST BENEFIT ANALYSIS METHODOLOGY

The following steps are prescribed for performing a business analysis of outpatient collection potential. MTFs shall follow these procedures when requesting an exemption to the requirement to implement an outpatient collections program. Contact your Service representative if it is necessary to deviate from these guidelines.

I. Claims:

A. Workload: Analysis of the costs and benefits for implementing an outpatient collection program is based on anticipated workload as the assumption is that there is a strong positive relationship between workload and the costs and benefits of the program.

1. Estimate the number of health insurance (OHI) claims per year that the MTF can anticipate. This will serve as the basis for determining the personnel and equipment costs along with projected collections.

2. Use the number of non-active duty outpatient visits multiplied by the percentage of non-active duty dispositions with OHI for the current and past year for the MTF. This will provide an indication of potential billable visits/claims excluding the impact of copays and deductibles. For the purposes of the cost benefit analysis, one claim per visit is assumed. For example, an MTF estimates they will have 43,000 outpatient visits and have had an average of 10 percent of non-active duty disposition with OHI for the past two years:

$$43{,}000 \times 10\% = 4{,}300 \text{ Annual OHI Claims}$$

II. Costs:

A. Manpower: The number of projected OHI claims processed annually by the MTF will be used to determine staffing requirements. One Full Time Equivalent Employee (FTE) per 2,860 claims per year is used as the standard for the purposes of this analysis. Divide the annual estimate of OHI claims by 2,860 to determine the number of FTEs that will be needed to perform outpatient billing. Round fractions upward to the next full FTE.

1. Divide the 4,300 annual OHI claims by 2,860 which results in 1.5 FTEs. One FTE can handle approximately 2,860 claims per year. Round upwards to the next whole number (2) to determine how many FTEs will be required to process these claims.

$$4{,}300 \div 2{,}860 = 1.503 \approx 2$$

2. If it is possible to obtain part-time help or use a portion of another FTE's time to perform other functions unrelated to outpatient collections round downward instead of upward.

3. Determine the grade level for the number of total FTEs required to process the estimated billable OHI claims (step 2 above) from the Civil Service Grade Level Table, (Table 1). Read down column one until you find the calculated number of FTEs the facility requires and then across to determine the grade level distribution. In the example above, a requirement for 2 FTEs was determined. Read down column one until you find 2. Reading across you will note that the projected grade level distribution is 1 GS 4-4 and 1 GS 5-4.

4. Use the Civil Service Labor Estimate Table (Table 2) to determine the estimate of annual labor costs for the grade level identified in step 3. Civil Service Step 4 is used as the step level for each grade. Multiply the number of FTEs times the appropriate annual total labor cost for the GS grade for CY93 to determine the total annual labor cost.

a. For example:

One GS4	$24,704.38
One GS5	27,641.94
Total	$52,346.32

b. Add 1/2 month of labor cost for each grade level (salary and benefits) to the total labor costs calculated above to estimate the cost of two weeks of staff training prior to implementation of the program.

(1) Monthly Labor cost x 0.5 equals Training cost estimate:

(1 GS4 + 1 GS5) x .5 = Training cost =
($2,059 + $2,303) x .5 = $2,181 Training cost

(2) Annual labor cost plus the training cost equals the total personnel cost:

$52,346 + $2,181 = $54,527 Total Personnel cost

B. Hardware Requirement: A standard hardware configuration has been developed based on the expected billable workload. Purchase of hardware which exceeds the configuration developed following this methodology must be approved by the Service Headquarters.

1. Determine the system configuration needed for the projected number of claims for an outpatient collections program from the Standard Hardware Requirements Table (Table 3). Obtain estimates from commercial vendors if purchase of commercial software is contemplated. Otherwise use the GSA price schedule or other appropriate government computer purchase contract to price out the cost of the hardware. It may be necessary to get quotes from several vendors to be confident of the cost of a commercial off the shelf (COTS) system.

a. The basic system configuration is a host file server with additional terminals being networked off it (if justified by the work load). Additional terminals may be 386 or 486 PCs or basic "dumb" terminals with no stand-alone processing capability.

b. Divide the number of annual billable OHI OPVs by 5,200 (the number of claims each terminal can process a year) to determine how many terminals, in addition to a host console/file server, will be needed. 5,200 claims per FTE per year is the standard for the purposes of developing the cost benefit analysis. One terminal for every two FTEs or fraction of an FTE is used as the standard for this analysis. Using the number of billable visits determined earlier (4,300), divide by 5,200 which equals 0.83. Round down to determine the number of additional terminals. No additional terminals are required in this example:

4,300/5,200 = 0.83 which is less than 1

c. Include the following items in the cost estimate if applicable:

- File Server
- LAN/Terminal Communications (if required)
- Operating System Software
- User License (if applicable)
- Application Software
- PCs/"Dumb" Terminals
- Printers
- Modems
- Installation Costs

C. Operating Costs: Operating costs include the cost of materials used in processing a claim such as supplies, postage, forms, reproduction and telephone. Operating costs are expressed on a per claim basis in order to simplify computation of operating costs in relation to workload. Multiply the annual number of billable OHI OPV claims by $0.95 (the DoD standard cost per claim) to determine an estimate of the operating costs.

4,300 x $0.95 = $4,085 Operating cost

D. Total costs: Sum the manpower, hardware, and operating costs to determine the total cost of operating an outpatient billing function:

Manpower	$54,527
Hardware/Software	14,000
Operating cost	4,085
	$72,612

III. Benefits: A variety of reductions, such as deductibles and copayments, have a significant impact on the estimate of outpatient collections. Determination of reasonably accurate

estimates of outpatient collections require adjustments of gross billings for these known reductions.

A. Collections:

1. Multiply the number of annual billable OHI OPVs by the current outpatient rate ($100 for FY93).

4,300 x $100 = $430,000

2. Multiply the amount obtained in step 1 above by 0.55. This is the projected collection rate goal for FY93. This amount will be further reduced by the outpatient deductible and copayment which will result in an estimate of collections.

$430,000 x 0.55 = $236,500

3. Calculate the outpatient deductible by multiplying the amount in step 1 above by 0.32 which allocates a $200 deductible over each billable OPV.

$430,000 x 0.32 = $137,600

4. Calculate the patient copayment.

(a) First subtract the total OP deductible amount from step 3 from the total annual billings amount from step 1 so that only the cases of patients who have met their deductible will remain. It is at this point (after the deductible has been met) that the copay becomes relevant.

$430,000 - 137,600 = $292,400

(b) Divide the above total by 102.5 to estimate the total number of billable OHI OPV claims for which the deductible has been met.

$292,400 ÷ 102.5 = 2,853

(c) Multiply the above result by $5.25 to arrive at the total amount of the copayment. This is the average copayment amount.

2,853 x $5.25 = $14,978

5. Subtract the total obtained during steps 3 and 4 above, from the amount from step 2. This is an estimate of the annual collections for the MTF.

$236,500 - 137,600 - 14,978 = $83,922

B. Residual Value of Equipment: Equipment used in an interim solution is expected to have some useful life following implementation of the standard solution. This remaining useful life is expressed as residual value.

1. Use the total value of the hardware requirements defined in II.B. If purchase of a COTS system which includes

hardware is contemplated, do not use the hardware costs charged by the vendor. Multiply the total estimated costs by the following factors to determine the residual value of the projected hardware configuration:

.80 - 486 PCs
.40 - 386 PCs
.80 - High Speed Printers
.80 - Low Speed Printers
.80 - Modems
.00 - "Dumb" Terminals

486 PC	$3,300 x .80 = $2,640
High Speed Printer	$480 x .80 = $384
Low Speed Printer	$225 x .80 = $180

$2,640 + 384 + 180 = $3,204

No value is attributed to the vendor-provided software since it is assumed that it will not be useful once the standard system becomes operational.

IV. Net Cost Benefit Determination

A. Total Benefits:

1. Add the amounts from steps III.A.5 and III.B.1 to determine the total benefits from performing outpatient billing at the MTF.

$83,922 + 3,204 = $87,126

B. Net Cost/Benefit:

1. Subtract the amount from step II.D (total costs) from the above result (total benefits). If the amount remaining is greater than zero, it is cost effective to initiate an outpatient billing program. If it is less than zero, then it is not cost effective to conduct an outpatient billing program. In this example, the difference is larger than 0, so it is cost effective to implement the outpatient program.

$87,126 - 72,612 = $14,514

Civil Service Grade Level Table

TOTAL PERS REQ	GS 4-4	GS 5-4	GS 6-4	GS 7-4	GS 8-4	GS 9-4	GS 10-4	GS 11-4	GS 12-4	GS 13-4	Total Cost Est. 1993	Total Cost Est. 1994
0	0	0	0	0	0	0	0	0	0	0	$0	$0
1 or less	1	0	0	0	0	0	0	0	0	0	$24,704	$25,446
2	1	1	0	0	0	0	0	0	0	0	$52,345	$53,916
3	2	1	0	0	0	0	0	0	0	0	$77,050	$79,361
4	2	1	0	1	0	0	0	0	0	0	$111,283	$114,621
5	3	1	0	1	0	0	0	0	0	0	$135,987	$140,067
6	3	2	0	1	0	0	0	0	0	0	$163,628	$168,537
7	4	2	0	1	0	0	0	0	0	0	$188,332	$193,982
8	4	2	0	1	0	1	0	0	0	0	$230,210	$237,116
9	4	3	0	1	0	1	0	0	0	0	$257,851	$265,587
10	5	3	0	1	0	1	0	0	0	0	$282,555	$291,032
11	5	3	0	2	0	1	0	0	0	0	$316,788	$326,292
12	6	3	0	2	0	1	0	0	0	0	$341,493	$351,737
13	6	3	1	2	0	1	0	0	0	0	$372,299	$383,468
14	6	3	2	2	0	1	0	0	0	0	$403,105	$415,198
15	7	3	2	2	0	0	0	1	0	0	$436,602	$449,700
16	7	4	2	2	0	0	0	1	0	0	$464,243	$478,170
17	8	4	2	2	0	0	0	1	0	0	$488,948	$503,616
18	8	4	2	2	0	1	0	1	0	0	$530,825	$546,750
19	9	4	2	2	0	1	0	1	0	0	$555,530	$572,195
20	9	5	2	2	0	1	0	1	0	0	$583,171	$600,666
21	9	5	2	3	0	1	0	1	0	0	$617,403	$635,926
22	10	5	2	3	0	1	0	1	0	0	$642,108	$661,3.1
23	10	6	2	3	0	2	0	1	0	0	$711,626	$732,975
24	10	6	2	3	0	2	0	1	0	0	$711,626	$732,975
25	11	6	2	3	0	2	0	1	0	0	$736,331	$758,421
26	12	6	2	3	0	2	0	1	0	0	$761,035	$783,866
27	12	6	3	3	0	2	0	1	0	0	$791,841	$815,597
28	13	6	3	3	0	2	0	1	0	0	$816,546	$841,042
29	13	6	3	4	0	2	0	1	0	0	$850,779	$876,302
30	13	7	3	4	0	2	0	1	0	0	$878,420	$904,772
31	14	7	3	4	0	2	0	1	0	0	$903,124	$930,218
32	14	7	4	4	0	2	0	0	1	0	$943,989	$972,309
33	15	7	4	4	0	2	0	0	1	0	$968,693	$997,754
34	16	7	4	4	0	2	0	0	1	0	$993,398	$1,023,200
35	16	8	4	4	0	2	0	0	1	0	$1,021,039	$1,051,670
36	16	8	5	4	0	2	0	0	1	0	$1,051,845	$1,083,400

Table (1)

Civil Service Labor Estimate Table*

	1992 Salary	Percent Benefits	Total 1992 Labor	COLA CY 93/92	Total 1993 Labor Costs	COLA CY 94/93	Total 1994 Labor Costs
GS-4	$17,389.00	37.00%	$23,822.93	3.70%	$24,704.38	3.00%	$25,445.51
GS-5	$19,456.00	37.00%	$26,654.72	3.70%	$27,640.94	3.00%	$28,470.17
GS-6	$21,684.00	37.00%	$29,707.08	3.70%	$30,806.24	3.00%	$31,730.43
GS-7	$24,096.00	37.00%	$33,011.52	3.70%	$34,232.95	3.00%	$35,259.93
GS-8	$26,689.00	37.00%	$36,563.93	3.70%	$37,916.80	3.00%	$39,054.30
GS-9	$29,477.00	37.00%	$40,383.49	3.70%	$41,877.68	3.00%	$43,134.01
GS-10	$32,463.00	37.00%	$44,474.31	3.70%	$46,119.86	3.00%	$47,503.46
GS-11	$35,666.00	37.00%	$48,862,42	3.70%	$50,670.33	3.00%	$52,190.44
GS-12	$42,746.00	37.00%	$58,562.02	3.70%	$60,728.81	3.00%	$62,550.68
GS-13	$50,830.00	37.00%	$69,637.10	3.70%	$72,213.67	3.00%	$74,380.08

*GS levels taken from step four of 1992 pay schedules

	Monthly Total 1993 Labor Costs	Monthly Total 1994 Labor Costs
GS-4	$2,059	$2,120
GS-5	$2,303	$2,373
GS-6	$2,567	$2,644
GS-7	$2,853	$2,938
GS-8	$3,160	$3,255
GS-9	$3,490	$3,595
GS-10	$3,843	$3,959
GS-11	$4,223	$4,349
GS-12	$5,061	$5,213
GS-13	$6,018	$6,198

Standard Hardware Requirements Table

HARDWARE	MINIMUM REQUIREMENTS
Host/File Server	1 at each main site, control console CRT to be used in lieu of 1st PC/Terminal. Operating system & system level utilities are to be bundled with host/file server
LAN/or Other Communications	0 if no main site PCs/terminals, 1 connection for each main site PC/terminal. Communication software is to be bundled with this equipment.
# Main Site Shared Printers	2 each MSA site, 1 of which may be high speed (e.g. MSLP) for MSA sites having over 2,600 claims/yr.
PC/Terminal	Minimum of 1 at each branch clinic, minimum of 0 at each main site. Add 1 per 5,200 claims/yr. Operating system & system level utilities are to be bundled with PC/terminal.
Modems	1 set per branch clinic (remote) PC/terminal unless multiplexed (MUX) modems are used, in which case, use manufacturer's guidelines. Bundle modem software in with modem.
Dot Matrix Printers	1 dot matrix directly attached to each branch clinic (remote) PC/terminal, none required for main site PC/terminals.

DEPARTMENT OF DEFENSE
THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION

(Read Privacy Act Statement on back before completing this form.)

Form Approved
OMB No. 0704-0323
Expires Mar 31, 1994

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO EITHER OF THESE ADDRESSES. RETURN COMPLETED FORM TO REQUESTING MEDICATION TREATMENT FACILITY

SECTION I - PATIENT INFORMATION

1. NAME (Last, First, Middle Initial)	2. PATIENT SSN	3. DATE OF BIRTH (YYMMDD)
Bateman, Linda B.	284-54-9624	861116

4. ADDRESS (Street, City, State and Zip Code)	5. TELEPHONE NUMBER (Include Area Code)	6. SPONSOR'S BRANCH OF SERVICE
1234 Plan Street Lost Lake, KY 40868	a. HOME: 606-485-9981 b. OFFICE: —	Air Force 7. FAMILY MEMBER PREFIX (FMP)/SPONSOR SSN: 03-987-65-4321 8. RELATION OF PATIENT TO INSURED: Child

9. IS PATIENT'S CONDITION RELATED TO AN ACCIDENT? [ ] YES (Complete a.-e.) [X] NO (Complete d.-e.)

a. TYPE OF ACCIDENT (X one)	b. DATE OF ACCIDENT (YYMMDD)	c. HOUR	d. DATE OF ADMISSION/ VISIT (YYMMDD)	e. HOUR
[ ] AUTO ACCIDENT (Comply with information requirements as stated in DoDI 6010.15) [ ] OTHER			921113	10:00

f. IS PATIENT COVERED BY ANY MEDICAL INSURANCE? [X] YES [ ] NO *(If "Yes," complete Section II. If "No," go to Section IV.)*

SECTION II - INSURANCE CARRIER INFORMATION *(Complete for all Health Insurance policies and employers.)*

10. EMPLOYER OF INSURED

a. NAME	b. TELEPHONE NUMBER (Incl. Area Code / Extension)	c. ADDRESS (Street, City, State and Zip Code)
Buron Manufacturing Co.	606-984-0272	1776 State Street Lost Lake, KY 40862

11. PRIMARY MEDICAL INSURANCE POLICY

a. INSURANCE TYPE (X one)		b. NAME OF INSURED (Last, First, Middle Initial)	c. SSN
[ ] GROUP HEALTH PLAN [X] COMMERCIAL	[ ] CHAMPUS/CHAMPVA [ ] SUPPLEMENTAL CHAMPUS [ ] SUPPLEMENTAL MEDICARE	Bateman, Rita N.	987-65-9921

d. NAME OF GROUP INSURANCE PLAN (If applicable)	e. GROUP PLAN NUMBER
NA	NA

f. INDIVIDUAL POLICY NUMBER	g. GROUP POLICY NUMBER	h. EFFECTIVE DATE (YYMMDD)	i. RENEWAL DATE (YYMMDD)
987659921	A21381	91-07-14	—

j. COMMERCIAL INSURANCE COMPANY	k. FAMILY MEMBERS COVERED BY THIS POLICY		
(1) NAME: Country Life & Casualty	(1) NAME (Last, First, Middle Initial)	(2) DATE OF BIRTH (YYMMDD)	(3) SSN
(2) TELEPHONE NUMBER (Include Area Code / Extension): 606-749-2331 (5507)	Bateman, Rita N.	581016	987-65-9921
(3) ADDRESS (Street, City, State and Zip Code): 32 Capital Street, Suite 16 Little Rock, KY 40210	Bateman, Linda B.	861116	284-54-9624
	Bateman, Brandon N.	900519	492-18-2755

12. OTHER MEDICAL INSURANCE POLICIES *(Use additional pages as necessary.)*

a. INSURANCE TYPE (X one)		b. NAME OF INSURED (Last, First, Middle Initial)	c. SSN
[ ] GROUP HEALTH PLAN [ ] COMMERCIAL	[ ] CHAMPUS/CHAMPVA [ ] SUPPLEMENTAL CHAMPUS [ ] SUPPLEMENTAL MEDICARE		

d. NAME OF GROUP INSURANCE PLAN (If applicable)	e. GROUP PLAN NUMBER

f. INDIVIDUAL POLICY NUMBER	g. GROUP POLICY NUMBER	h. EFFECTIVE DATE (YYMMDD)	i. RENEWAL DATE (YYMMDD)

j. COMMERCIAL INSURANCE COMPANY	k. FAMILY MEMBERS COVERED BY THIS POLICY		
(1) NAME	(1) NAME (Last, First, Middle Initial)	(2) DATE OF BIRTH (YYMMDD)	(3) SSN
(2) TELEPHONE NUMBER (Include Area Code / Extension)			
(3) ADDRESS (Street, City, State and Zip Code)			

DD Form 2569, SEP 92 *Previous edition may be used*

SECTION III - PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095; EO 9397.

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to military dependents and retirees. Such monetary benefits accruing to the Military Medical Facility will be used to enhance health care delivery in the Medical Treatment Facility. Information will also be used by Military Treatment Facility staff and CHAMPUS Fiscal Intermediaries (FI's) to determine eligibility for care, deductibles, and co-shares.

ROUTINE USE(S): The information on this form will be released to your insurance company, and to Medical Treatment Facility staff, CHAMPUS FI's, and providers.

DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services and in a higher cost to you for medical care.

SECTION IV - RELEASE AND ASSIGNMENT

I acknowledge that portions of my medical records necessary to support claims for reimbursement for the cost of care rendered may be released to my insurance carriers.

I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10 U.S. Code, Section 1095, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for hospitalization or outpatient services provided me and/or my dependents.

SECTION V - CERTIFICATIONS

I certify that the information on this form is true and accurate to the best of my knowledge.

a. SIGNATURE OF PATIENT OR ADULT FAMILY MEMBER/SPONSOR	b. DATE SIGNED *(YYMMDD)*
Rita Bateman	921113
c. SIGNATURE OF CLERK	d. DATE SIGNED *(YYMMDD)*
	921113

SECTION VI - REGISTRATION VERIFICATION

NOTE: Verification of insurance coverage shall be made upon the occasion of each admission or outpatient visit to the Medical Treatment Facility. Any time information on this form is changed a new signature must be obtained. Annually, on the first visit after twelve months have passed since the patient's signature was first obtained, a new form must be completed and signed.

I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

a. FIRST VERIFICATION (1) SIGNATURE Rita Bateman	(2) DATE SIGNED *(YYMMDD)* 921229
b. SECOND VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
c. THIRD VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
d. FOURTH VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
e. FIFTH VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*
f. SIXTH VERIFICATION (1) SIGNATURE	(2) DATE SIGNED *(YYMMDD)*

INSTRUCTIONS FOR COMPLETING DD Form 2569, "THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION"

Purpose: This form shall be used as the vehicle to elicit information from inpatient and outpatient beneficiaries as to the availability of health insurance coverage and to obtain the information needed to bill third party payers. The signed form documents that all beneficiaries were questioned regarding insurance coverage and serves as a record of their response. Any time information on the form is changed, a new signature must be obtained. Annually, on the first visit after 12 months have passed since the patient's signature was first obtained a new form must be completed and signed. Distribution of the DD Form 2569, "Third Party Collection Program - Insurance Information," is addressed in the basic instruction. Report Control Symbol DD-HA(Q) 1856 is assigned.

Instructions:

Section I - Patient Information

1. Name (Last, First, Middle Initial): Enter the name of the patient being admitted or treated on an outpatient basis.

2. Patient SSN: Enter the social security number of the patient.

3. Date Of Birth (YYMMDD): Enter the date of birth for the patient being admitted or treated on an outpatient basis.

4. Address (Street, City, State and Zip Code): Enter the home address for the patient being admitted or treated on an outpatient basis.

5. Telephone Number (Include Area Code): Enter the (a) Home and (b) Office telephone numbers for the patient being admitted or treated on an outpatient basis.

6. Sponsor's Branch Of Service: Enter the military branch of Service of the sponsor.

7. Family Member Prefix (FMP)/Sponsor SSN: Enter the FMP for the patient and the sponsor's social security number.

8. Relation Of Patient To Insured: If the patient is other than the insured, indicate the relationship, i.e., wife, husband, daughter, son, etc.

9. Is Patient's Condition Related To An Accident?: If the visit or admission is related to an accidental injury, indicate by checking either the Yes (Complete a - e) or No (Complete d-e) block. If yes, then complete blocks a - e:

a. Type Of Accident (X One): Indicate whether the accident was an auto accident or another type of accident. If condition is due to an auto accident comply with information requirements as stated above in F.3.v.

b. Date Of Accident(YYMMDD): Enter the date the accident occurred.

c. Hour: Enter the time the original accident occurred.

d. Date Of Admission/Visit (YYMMDD): Enter the date of the admission or of the outpatient visit.

e. Hour: Enter the time of the admission or outpatient visit.

f. Is Patient Covered By Any Medical Insurance: If the patient is covered by any medical insurance, indicate by checking either the "YES" or "NO" block. If yes, then complete Section II. If no, go to Section IV.

Section II - Insurance Carrier Information
(Complete For All Health Insurance Policies And Employers.)

10. Employer of Insured. Enter the (a) Name of the employer, (b) Telephone Number (Include Area Code/Extension), and (c) Address (Street, City, State and Zip Code).

11. Primary Medical Insurance Policy: For the primary medical insurance company enter the following information:

a. Insurance Type (X One): Choose from Group Health Plan, Commercial, CHAMPUS/CHAMPVA, Supplemental CHAMPUS, or Supplemental Medicare. If primary insurance policy is CHAMPUS/CHAMPVA or Supplemental CHAMPUS it is not necessary to provide any more information as legislation does not allow billing of CHAMPUS.

b. Name Of Insured (Last, First, Middle Initial): Enter the name of the person under which the health insurance policy is issued.

c. SSN: Enter the social security number of the health insurance policy holder.

d. Name Of Group Insurance Plan (If Applicable): If coverage is provided by group insurance plan, wherein the employer or union assumes all or part of the responsibility for paying claims, enter the plan name.

e. Group Plan Number: If coverage is provided by group insurance plan, such as an employer paid plan, enter the plan number.

f. Individual Policy Number: Enter the insurance holder's individual policy number, their unique identifier issued by the insurance company.

g. Group Policy Number: Identifier issued by the insurance company to match the individual policy holder to a group.

h. Effective Date (YYMMDD): The date that insurance coverage becomes effective (information may not be present on the insurance card).

i. Renewal Date (YYMMDD): The date that the patient is required to renew their coverage or that the insurance is effective through (information may not be present on the insurance card).

j. Commercial Insurance Company: Any corporation primarily engaged in the business of furnishing insurance protection to the public.

(1) Name: Enter the insurance company's name.

(2) Telephone Number (Include Area Code/Extension): Enter the telephone number for the insurance company billing office.

(3) Address (Street, City, State and Zip Code): Enter the billing address for the individual insurance company.

k. Family Members Covered By This Policy: List the various family members that are covered by this policy.

(1) Name (Last, First, Middle Initial): Enter each family member covered by the policy.

(2) Date of Birth (YYMMDD): Enter for each family member covered by the policy.

(3) SSN: Enter the social security number for each family member covered by the policy.

12. Other Medical Insurance Policies (Use Additional Pages as Necessary):

Block 12 is a repeat of block 11. Instructions provided for block 11 are applicable to block 12 as well.

Section V - Certifications

13. Signature of Patient or Adult Family Member/Sponsor: The patient or responsible family member should read the certification statement prior to signing and dating the form in items a and b.

14. Signature of Clerk: In those instances in which Section I, Block 9 is checked "YES", the form must be reviewed by the person designated to review potential third party liability cases. A clerk's signature verifies that the patient was questioned about potential coverage by other health insurance or as a third party liability case.

Section VI - Registration Verification

15. First Verification: At each occasion of an admission or outpatient visit the patient or responsible family member should read the verification statement prior to signing and dating the form at items (1) and (2). Annually, on the first visit after twelve months have passed since the patient's signature was first obtained, a new form must be completed and signed.

INSURANCE BILLING REQUIREMENTS

Table 1

Beneficiary Category	Inpatient Hospital Billing	Outpatient Visit Billing	Ancillary Services Billing	No-Fault Accident Billing
Active Duty	NO	NO	NO	YES
Retiree	YES	YES	YES	YES
Dependent	YES	YES	YES	YES

Type of Insurance Policy to be Billed	Inpatient	Outpatient	Ancillary
Private Enrollment Plan	YES	YES	YES
Group Health Plan	YES	YES	YES
Employer Health Plan	YES	YES	YES
Association/Organization Health Plan	YES	YES	YES
No-Fault Automobile Insurance	YES	YES	YES
Third Party Automobile Liability (Tort Claim)	YES	YES	YES
Medicare Supplemental Plan	YES	NO	NO
CHAMPUS Supplement	NO	NO	NO
Income Supplement	NO	NO	NO

Third Party Collection Program
Tips for Report Preparation

Type Insurance & Report Source — Table 2

	Report Program Results DD 2570	Aging Schedule DD 2571	Collection Source Analysis DD 2607	Insurance Type Report DD 2608
Inpatient Medical Insurance	Included	Included	Included	Included Part I, Block (2)
Outpatient Medical Insurance	Included	Included	Included	Included Part II, Block (2)
Medicare Supplemental	Included	Included	Included	Included Part I, Block (4)
No Fault Automobile	Excluded	Excluded	Excluded	Included Part I,II Block (3)
Third Party Liability	Excluded	Excluded	Excluded	Included Part I,II Block (5)
Ancillary Services/ Supplemental Billing Care	Excluded	Excluded	Excluded	Included Part I,II Block (5)

Third Party Collection Program
Tips for Report Preparation

Reporting of Patient Category by Form — Table 3

	Report Program Results DD 2570	Aging Schedule DD 2571	Collection Source Analysis DD 2607	Insurance Type Report DD 2608
Active Duty	**Excluded**	**Excluded**	**Excluded**	Included Separate Block Part I & II
Dependent Active Duty	Part of Total	Part of Total	Separate Line Section I Part A & B	Separate Block Part I & II
Retired	Part of Total	Part of Total	Separate Line Section I Part A & B	Separate Block Part I & II
Dependent Retired	Part of Total	Part of Total	Separate Line Section I Part A & B	Separate Block Part I & II
Dependent Deceased	Part of Total	Part of Total	Separate Line Section I Part A & B	Separate Block Part I & II
Other	Part of Total	Part of Total	Separate Line Section I Part A & B	Separate Block Part I & II

Reconciliation Among Reports — Table 4

	Report Program Results DD 2570	Aging Schedule DD 2571	Collection Source Analysis DD 2607	Insurance Type Report DD 2608
Number of Claims - Inpatient	Part I, Block 4, Column (3) by Fiscal Year	N/A	N/A	Part I, Line 11, Column (2)(a) PLUS Line 11, Column (4)(a) by Fiscal Year
Number of Claims - Outpatient	Part I, Block 4, Column (3) by Fiscal Year	N/A	N/A	Part II, Line 18, Column (2)(a) PLUS Line 18, Column (4)(a) by Fiscal Year
Amount Billed - Inpatient	Part I, Block 4, Column (6) by Fiscal Year	N/A	Section I, Part A, Line 11, Column e, Total. Current Fiscal Year Only	Part I, Line 11, Column (2)(b), Total PLUS Line 11, Column (4)(b), Total by Fiscal Year
Amount Billed - Outpatient	Part II, Block 4, Column (6) by Fiscal Year	N/A	Section I, Part B, Line 18, Column c, Total. Current Fiscal Year Only	Part II, Line 18, Column (2)(b), Total PLUS Line 18, Column (4)(b), Total by Fiscal Year
Amount Collected - Inpatient	Part I, Block 4, Column (10) by Fiscal Year	N/A	Section I, Part A, Line 11, Column f, Total. Current Fiscal Year Only	Part I, Line 11, Column (2)(c), Total PLUS Line 11, Column (4)(c), Total Current Fiscal Year Only
Amount Collected - Outpatient	Part II, Block 4, Column (10) by Fiscal Year	N/A	Section I, Part B, Line 18, Column d, Total. Current Fiscal Year Only	Part II, Line 18, Column (2)(c), Total PLUS Line 18, Column (4)(c), Total, Current Fiscal Year Only
Amount Uncollected - Inpatient	Part I, Block 4, Column (11) PLUS Part II, Block 4, Column (11) by Fiscal Year	Block 4a, Column (11), Total/Grand Total by Fiscal Year (Includes Inpatient & Outpatient Uncollected Claims)	N/A	N/A
Amount Uncollected - Outpatient			N/A	N/A

Third Party Collection Program
Tips for Report Preparation

Additional Reconciliations			Table 4
	Report Program Results DD 2570 Part I	Report Program Results DD 2570 Part II	Aging Schedule DD 2571
$ Adjustments and Refunds - Inpatient Block 4, Column (7)	Block 4, Column (7) by Fiscal Year	Total of All Closed Claims (Reason Codes 8 through 16) by Fiscal Year	N/A
$ Adjustments and Refunds - Outpatient Block 4, Column (7)	Block 4, Column (7) by Fiscal Year	Total of All Closed Claims (Reason Codes 8 through 16) by Fiscal Year	N/A
$ Amount Remaining Uncollected - Inpatient (6)-[(7)+(8)+(9)+(10)] Block 4, Column (11)	Block 4, Column (11) by Fiscal Year	Total of All Open Claims (Reason Codes 1 through 7) by Fiscal Year	Block 4a, Column (11) Total/ Grand Total by Fiscal Year (Includes Inpatient and Outpatient Uncollected Claims)
$ Amount Remaining Uncollected - Outpatient (6)-[(7)+(8)+(9)+(10)] Block 4, Column (11)	Block 4, Column (11) by Fiscal Year	Total of All Open Claims (Reason Codes 1 through 7) by Fiscal Year	

Third Party Collection Program
Tips for Report Preparation

Fiscal Year Identity by Form — Table 5

	Report Program Results DD 2570	Aging Schedule DD 2571	Collection Source Analysis DD 2607	Insurance Type Report DD 2608
Current Year Identity	Yes	Yes	Current Fiscal Year Only	Yes
PY1 - Previous Year 1 Identity	Yes	Yes	No	Yes
PY2 - Previous Year 2 Identity	Yes	Yes	No	Yes
Any Claims Prior to PY2	As Addendum to DD 2570 and Detail Report	As Addendum to DD 2571 and Detail Report	No	No
Total All Years	No	Yes	No	No

THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS

SEGMENT REPORTED (Check One)		REPORT CONTROL SYMBOL
X	INPATIENT	DD-HA(Q)1854
	OUTPATIENT	

1. QUARTER ENDING (MMMYY) MAR93
2. REPORTING MEDICAL TREATMENT FACILITY (MTF) 123rd General Hospital, Knoxville KY
3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO. 0985

PART I

Date of Report: 930403

4. REPORTING PERIOD *(See Note 1)*

FISCAL YEAR (FY) (1)	NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS/VISITS (2)	NO. OF CLAIMS (3)	NO. OF COLLECTIONS (4)	NO. CLAIMS DIVIDED BY DISPOSITIONS/ VISITS (%) (5)	TOTAL $ AMOUNT BILLED/CHARGES (6)
a. CURRENT FY 93	22,940	1,693	609	7.38%	205,765.00
PRIOR YEAR (PY)					
b. PY 1 92	64,557	4,222	2,952	6.54%	537,328.00
c. PY 2 91	69,618	3,098	1,773	4.45%	234,066.00

	$ ADJUSTMENTS AND REFUNDS *(See Note 2)* (7)	$ AMOUNT COLLECTED PY 2 (8)	$ AMOUNT COLLECTED PY 1 (9)	$ AMOUNT COLLECTED CURRENT FY (10)	$ AMOUNT REMAINING UNCOLLECTED *(See Note 3)* (6) - [(7) + (8) + (9) + (10)] (11)
a. CURRENT FY 93	8,918.55			121,062.42	75,784.03
b. PY 1 92	95,074.54		239,144.77	156,070.09	47,038.60
c. PY 2 91	57,560.27	89,641.73	50,126.45	20,011.28	16,726.27

PART II

REASON CODES	5. DISTRIBUTION OF REMAINING UNCOLLECTED AMOUNTS	6. UNCOLLECTED AMOUNTS SUBDIVIDED BY FY ($) *(See Notes 1 and 4)* a. FY 93	b. FY 92	c. FY 91
1	OPEN CLAIMS *(Requires additional follow-up action by Medical Treatment Facility for resolution)*	45,217.03	4,583.69	1,270.84
2	TRANSFERRED TO EXTERNAL AGENT *(e.g., DAO) (Excluding Third Party Liability Cases)*	9,108.27	16,678.91	10,377.43
	REASON CODES 3-7. THIRD PARTY REDUCED/DENIED PAYMENT FOR INVALID REASONS *(Requires additional debt collection/legal action)*			
3	MTF NOT A PARTICIPATING HOSPITAL	12,474.00	14,781.00	2,904.00
4	PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES	8,442.73	3,073.00	1,470.00
5	PATIENT HAD NO OBLIGATION TO PAY	0	7,922.00	704.00
6	INSURER PAID PATIENT DIRECTLY	542.00	0	0
7	OTHER *(Explain)*	0	0	0
	TOTAL OF ALL OPEN CLAIMS *(Reason Codes 1 through 7)*	75,784.03	47,038.60	16,726.27
	REASON CODES 8-16. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS *(No further action required because unpaid amount is not a valid claim)*			
8	AMOUNT OF COVERAGE *(i.e. plan pays less than 100%)*	2,414.98	57,499.16	27,592.93
9	PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED	1,976.00	4,898.00	16,301.40
10	CHAMPUS AND/OR INCOME SUPPLEMENTAL PLANS	701.00	13,042.73	7,042.18
11	MEDICARE SUPPLEMENTAL PLANS	527.07	0	0
12	HEALTH MAINTENANCE ORGANIZATION (HMO) *(i.e. nonemergency out-of-plan care not covered)*	0	1,402.00	0
13	MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES *(i.e. pre-admission screening, concurrent review, second surgical opinions, etc.)*	1,470.00	18,232.65	6,623.76
14	REFUNDS	701.00	0	0
15	PATIENT COPAYS AND DEDUCTIBLES	1,128.50	0	0
16	OTHER *(Explain) (Example - third party provided lower prevailing rate vs. amount billed)*	0	0	0
	TOTAL OF ALL CLOSED CLAIMS *(Reason Codes 8 through 16)*	8,918.55	95,074.54	57,560.27

NOTES:

1. All activity for amounts claimed and collected shall be reported in the fiscal year that the services were rendered (i.e., care provided in FY 1989 will be reported as an FY 1989 claim and collection, regardless of the year payment is received). This requires cut-off billing for all inpatients at fiscal year end.
2. Amounts reported in Part I, Column (7) for each fiscal year shall equal the subtotal for Reason Codes 8 - 16 in Part II, for the respective fiscal years.
3. Amounts reported in Part I, Column (11) for each fiscal year shall equal the subtotal for Reason Codes 1 - 7 in Part II, for the respective fiscal years.
4. Each quarterly report shall be cumulative for the current and two prior fiscal years.

THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS

SEGMENT REPORTED (Check One)		REPORT CONTROL SYMBOL
	INPATIENT	DD-HA(Q)1905
X	OUTPATIENT	

1. QUARTER ENDING (MMMYY)	2. REPORTING MEDICAL TREATMENT FACILITY (MTF)	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NO.
MAR93	123rd General Hosp., Knoxville, KY	0985

PART I Date of Report: 930403

4. REPORTING PERIOD *(See Note 1)*

FISCAL YEAR (FY) (1)	NO. OF NON-ACTIVE DUTY INPATIENT DISPOSITIONS/VISITS (2)	NO. OF CLAIMS (3)	NO. OF COLLECTIONS (4)	NO CLAIMS DIVIDED BY DISPOSITIONS / VISITS (%) (5)	TOTAL $ AMOUNT BILLED / CHARGES (6)
a. CURRENT FY 93	25,028	2,678	139	1.0%	267,800
PRIOR YEAR (PY)					
b. PY 1 92	0	0	0	0	0
c. PY 2 91	0	0	0	0	0

	$ ADJUSTMENTS AND REFUNDS *(See Note 2)* (7)	$ AMOUNT COLLECTED PY 2 (8)	$ AMOUNT COLLECTED PY 1 (9)	$ AMOUNT COLLECTED CURRENT FY (10)	$ AMOUNT REMAINING UNCOLLECTED *(See Note 3)* *(6) - [(7) + (8) + (9) + (10)]* (11)
a. CURRENT FY 93	43,620			71,639	152,541
b. PY 1 92	0		0	0	0
c. PY 2 91	0	0	0	0	0

PART II

REASON CODES	5. DISTRIBUTION OF REMAINING UNCOLLECTED AMOUNTS	6. UNCOLLECTED AMOUNTS SUBDIVIDED BY FY ($) *(See Notes 1 and 4)* a. FY 93	b. FY 92	c. FY 91
1	OPEN CLAIMS *(Requires additional follow-up action by Medical Treatment Facility for resolution)*	54,705	0	0
2	TRANSFERRED TO EXTERNAL AGENT *(e.g., JAG) (Excluding Third Party Liability Cases)*	2,300	0	0
	REASON CODES 3 - 7. THIRD PARTY REDUCED / DENIED PAYMENT FOR INVALID REASONS *(Requires additional debt collection/legal action)*			
3	MTF NOT A PARTICIPATING HOSPITAL	19,567	0	0
4	PLAN EXCLUDES MILITARY HOSPITALS OR BENEFICIARIES	49,187	0	0
5	PATIENT HAD NO OBLIGATION TO PAY	25,969	0	0
6	INSURER PAID PATIENT DIRECTLY	813	0	0
7	OTHER *(Explain)*	0	0	0
	TOTAL OF ALL OPEN CLAIMS *(Reason Codes 1 through 7)*	152,541	0	0
	REASON CODES 8 - 16. CLOSED CLAIMS. THIRD PARTY PAID IN FULL OR REDUCED / DENIED PAYMENTS *(No further action required because unpaid amount is not a valid claim)*			
8	AMOUNT OF COVERAGE *(i.e. plan pays less than 100%)*	9,794	0	0
9	PATIENT NOT COVERED, CARE PROVIDED NOT COVERED, OR POLICY EXPIRED	11,206	0	0
10	CHAMPUS AND/OR INCOME SUPPLEMENTAL PLANS	677	0	0
11	MEDICARE SUPPLEMENTAL PLANS	3,323	0	0
12	HEALTH MAINTENANCE ORGANIZATION (HMO) *(i.e. nonemergency out-of-plan care not covered)*	825	0	0
13	MTF DID NOT COMPLY WITH UTILIZATION REVIEW PROCEDURES *(i.e. pre-admission screening, concurrent review, second surgical opinions, etc.)*	175	0	0
14	REFUNDS	1,433	0	0
15	PATIENT COPAYS AND DEDUCTIBLES	16,187	0	0
16	OTHER *(Explain)* *(Example - third party provided lower prevailing rate vs. amount billed)*	0	0	0
	TOTAL OF ALL CLOSED CLAIMS *(Reason Codes 8 through 16)*	43,620	0	0

NOTES:

1. All activity for amounts claimed and collected shall be reported in the fiscal year that the services were rendered (i.e. care provided in FY 1989 will be reported as an FY 1989 claim and collection, regardless of the year payment is received). This requires cut-off billing for all inpatients at fiscal year end.
2. Amounts reported in Part I, Column (7) for each fiscal year shall equal the subtotal for Reason Codes 8 - 16 in Part II, for the respective fiscal years.
3. Amounts reported in Part I, Column (11) for each fiscal year shall equal the subtotal for Reason Codes 1 - 7 in Part II, for the respective fiscal years.
4. Each quarterly report shall be cumulative for the current and two prior fiscal years.

INSTRUCTIONS FOR COMPLETING DD FORM 2570, "THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS," FOR INPATIENT COLLECTIONS

Purpose: This form shall be used to report on results of the MTFs' TPC Program for inpatient services. An inpatient summary report that consolidates the results of all the Service's MTFs shall be prepared by each Service. An automated version of the report is included within the Automated Quality of Care Evaluation Support System (AQCESS) Medical Summary Account (MSA) module. Report Control Symbol DD-HA(Q) 1854 is assigned.

Instructions:

1. Segment Reported (Check One): Check the appropriate block to indicate whether the report is for inpatient or outpatient collection results.

2. Quarter Ending (MMMYY): Enter the last month of the quarter and the Fiscal Year of the reporting period. For the cumulative report enter "CUM" after the month and year.

3. Reporting Medical Treatment Facility (MTF): Enter the reporting MTF or if a consolidated report, enter the branch of Service and reporting office.

4. Defense Medical Information System (DMIS) ID No.: Self-explanatory.

Part I

5. Reporting Period (See Note 1): Enter the data for the current fiscal year (FY) and the two prior years (PY 1 and PY 2) being reported in the appropriate boxes.

6. No. of Non-Active Duty Inpatient Dispositions/Visits: Exclude active duty and Third Party Liability dispositions. As this number includes patients who do not have other health insurance, this number of dispositions will not match other reports.

7. No. of Claims: Enter the total number of insurance policies billed for patients dispositioned during the FY specified. If multiple billings are sent to the same insurance company, as in the case of a follow-up, only one claim will be recorded. If two different insurance companies are ultimately billed for the same period of care, then the number of claims is two. Part I, item 4(3) minus item 4(4) on the inpatient report, by fiscal year, plus Part I, item 4(3) minus item 4(4) on the outpatient report, by fiscal year, must match item 4a(3) Total/Grand Total by fiscal year on the DD 2571. The number of claims in Part I, 4(3) must also equal the amount reported in

Part I, item 11(2)(a) plus item 11(4)(a) reported for each fiscal year on the DD 2608.

8. No. of Collections: Enter the number of collections made against billings. Multiple payments by one insurer against a billing for a single episode of care would count as one collection. Should payments be received from two different insurance companies that were billed for the same period of care, then two collections are counted.

9. No. of Claims Divided by Dispositions (%)/Visits: Self-explanatory.

10. Total $ Amount Billed/Charges: Record the total amount of billings for the patients dispositioned during the FY specified. Billing amounts shall be reported for the FY in which the patient is dispositioned regardless of when the bill is actually prepared. For instance, the amount billed for a patient discharged 30 Sep 92 is reported as FY 92 billed charges although a bill may not have been actually prepared until FY 1993. The total amount reported as billed/charges for the current fiscal year in this report shall equal the amount reported on Section I, Part A, item 11e on the DD 2607. It will also equal the total of Part I, item 11(2)(b) plus item 11(4)(b) on the DD 2608 for each fiscal year. Since MTFs are only authorized to collect the deductible amount ($676 for FY93) from Medicare supplemental insurance, the amount billed above the deductible will be reflected as an adjustment on Part II, reason code 11, "Medicare Supplemental Plans."

11. $ Adjustments and Refunds (See Note 2): For each FY, enter the amount of billings determined to be either invalid, justifiably reduced or denied by insurance companies, or refunded to the insurance companies. The amount for each FY in this column should equal the subtotal of reason codes 8 through 16 of the same FY in Part II of this report.

12. $ Amount Collected PY 2: Enter the amount of collections for prior year 2 billings received during prior year (PY) 2. For instance, if the report is for the First Quarter FY 1993, report the amount of collections for FY 1991 that were made in FY 1991. The amount collected in PY 2 should remain constant from one reporting period to the next. Note that no entry should be made in this column for the current year or PY 1.

13. $ Amount Collected PY 1: Enter the amount of collections for PY 2 and PY 1 billings that were received during PY 1. Using the example of a First Quarter report for FY 1993, collections for some of the patients dispositioned during 1991 (PY 2) may not have been collected until FY 1992 (PY 1). The amount collected in FY 1992 for patients dispositioned in FY 1991 should be reported on the PY 2 line (c) and should remain

constant from one reporting period to the next. The amount collected in FY 1992 for patients dispositioned in FY 1992 should be reported on the PY 1 line (b) and should remain constant from one reporting period to the next. No entry should be made in the column for the current year (line (a)).

14. $ Amount Collected Current FY: Enter the amount of collections for PY 2, PY 1 and the current year that were received during the current year. The total of the Current Year, PY 1, and PY 2 should equal the amount deposited to the appropriation of the MTF for third party collections for the current year. Amounts collected are deposited to the FY in which the collection is made regardless of the FY that the patient was dispositioned. The amount reported as collections in the current FY is expected to increase from one reporting period to the next. The amount collected for the Current Year should equal Section I, Part A, item 11f, on the DD 2607 and Part I, item 11(2)(c)a plus item 11(4)(c)a on the DD 2608.

15. $ Amount Remaining Uncollected (See Note 3) (6)-((7)+(8)+(9)+(10)): Enter the total amount remaining to be collected for each of the FYs being reported. The amount in this column for each FY should equal:

a. The total amount reported in item 6 of the report, reduced by the amounts reported in items 7, 8, 9, and 10.

b. The amount in the subtotal for reason codes 1 through 7 in Part II of this report.

c. The total on this report when added to the total of the outpatient report, by fiscal year, must match the Total/Grand Total amount, item 4a(11), reported by fiscal year on the TPCP-Aging Schedule, DD Form 2571.

Part II

16. Distribution of Remaining Uncollected Amounts: This section represents the current open accounts receivable for the activity's TPC Program. Reason Codes 2 through 7 represent invalid denials by insurance companies and require follow up action by the MTF. The subtotal for items 1 through 7 in Part II must equal the amount reported in Part I, item 4(11) of the report.

Reason Codes 8 through 16 represent valid amounts denied by third party payers. No follow-up action is required for claims closed because of reasons indicated in items 8 through 16. The subtotal for items 8 through 16 must equal the amount reported in item 4(7) in Part I of this report.

17. Date of Report: Enter the date the report was prepared at the top of the report, to the right of the words, "Part I".

INSTRUCTIONS FOR COMPLETING DD FORM 2570, "THIRD PARTY COLLECTION PROGRAM - REPORT ON PROGRAM RESULTS," FOR OUTPATIENT COLLECTIONS

Purpose: This form shall be used to report on results of the MTFs' TPC Program for outpatient services. An outpatient summary report that consolidates the results of all the Service's MTFs will be prepared by each Service. Submission of this version of the report is not required until an automated version of the report is included within standard supporting software or the MTF begins collection for outpatient care. Report Control Symbol DD-HA(Q) 1854 applies to the report of outpatient collections as well as inpatient collections.

Instructions:

1. Segment Reported (Check One): Check the appropriate block to indicate that this is a report of outpatient collections.

2. Quarter Ending (MMMYY): Enter the last month of the quarter and the Fiscal Year of the reporting period. For the cumulative report enter "CUM" after the month and year.

3. Reporting Medical Treatment Facility (MTF): Enter the reporting MTF or if a consolidated report, enter the branch of Service and reporting office.

4. Defense Medical Information System (DMIS) ID No.: Self-explanatory.

Part I

5. Reporting Period (See Note 1): Enter the data for the current fiscal year (FY) and prior years (PY 1 and PY 2) being reported in the appropriate boxes.

6. No. of Non-Active Duty Inpatient Dispositions/Visits: Exclude active duty and Third Party Liability dispositions. As this number includes patients who do not have other health insurance, this number of visits will not match other reports.

7. No. of Claims: Enter the total number of insurance policies billed for outpatients during the FY specified. If multiple billings are sent to the same insurance company, as in the case of a follow-up, only one claim will be recorded. If two different insurance companies are ultimately billed for the same visit, then the number of claims is two. Part I, item 4(3) minus item 4(4) on the inpatient report, by fiscal year, plus Part I, item 4(3) minus item 4(4) on the outpatient report, by fiscal year, must match item 4a(3) Total/Grand Total by fiscal year on the DD 2571. The number of claims in Part I, 4(3) must also

equal the amount reported in Part I, item 18(2)(a) plus item 18(4)(a) reported for each fiscal year on the DD 2608.

8. No. of Collections: Enter the number of collections made against billings. Multiple payments by one insurer against a billing for a single episode of care would count as one collection. Should payments be received from two different insurance companies that were billed for the same period of care, then two collections are counted.

9. No. of Claims Divided by Dispositions (%)/Visits: Self-explanatory.

10. Total $ Amount Billed/Charges: Record the total amount of billings for the outpatient visits during the FY specified. Billing amounts shall be reported for the FY in which the patient was seen on an outpatient basis regardless of when the bill is actually prepared. For instance, the amount billed for a patient with a reportable visit 30 Sep 92 would be reported as FY 92 billed charges although a bill may not have been actually prepared until FY 1993. The total amount reported as billed/charges for the current fiscal year in this report shall equal the amount reported in Section I, Part B, item 18c on the DD 2607. It will also equal the total of Part II, item 18(2)(b) plus item 18(4)(b) on the DD 2608, for each fiscal year.

11. $ Adjustments and Refunds (See Note 2): For each FY enter only the amount of billings determined to be either invalid, justifiably reduced or denied by insurance companies, or refunded to the insurance companies. The amount for each FY in this column should equal the subtotal of reason codes 8 through 16 of the same FY in Part II of this report.

12. $ Amount Collected PY 2: Enter the amount of collections for prior year 2 billings received during prior year (PY) 2. For instance, if the report is for the First Quarter FY 1993, report the amount of collections for FY 1991 that were made in FY 1991. The amount collected in PY 2 should remain constant from one reporting period to the next. Note that no entry should be made in this column for the current year or PY 1.

13. $ Amount Collected PY 1: Enter the amount of collections for PY 2 and PY 1 billings that were received during PY 1. Using the example of a First Quarter report for FY 1993, collections for some of the patients having outpatient visits during 1991 (PY 2) may not have been collected until FY 1992 (PY 1). The amounts collected in FY 1992 for patients having outpatient visits in FY 1991 should be reported on the PY 2 line (c) and should remain constant from one reporting period to the next. The amount collected in FY 1992 for patients dispositioned in FY 1992 should be reported on the PY 1 line (b) and should

remain constant from one reporting period to the next. No entry should be made in the column for the current year (line (a)).

14. $ Amount Collected Current FY: Enter the amount of collections for PY 2, PY 1 and the current year that were received during the current year. The total of the Current Year, PY 1, and PY 2 should equal the amount deposited to the appropriation of the MTF for third party collections for the current year. Amounts collected are deposited to the FY in which the collection is made regardless of the FY in which the reportable clinic visit occurred. Collections in the current FY will be fluid and will change from one reporting period to the next. The amount collected for the Current Year should equal Section I, Part B, item 18d. on the DD 2607 and Part II, item 18(2)(c)a plus item 18(4)(c)a on the DD 2608.

15. $ Amount Remaining Uncollected (See Note 3) (6)-((7)+(8)+(9)+(10)): Enter the total amount remaining to be collected for each of the FYs being reported. The amount in this column for each FY should equal:

a. The total amount reported in item 6 of the report, reduced by the amounts reported in items 7, 8, 9, and 10.

b. The amount in the subtotal for reason codes 1 through 7 in Part II of this report.

c. The total on this report when added to the total of the inpatient report by fiscal year must match the Total/Grand Total amount, item 4a(11), reported by fiscal year on the TPCP-Aging Schedule, DD Form 2571.

Part II

16. Distribution of Remaining Uncollected Amounts: This section represents the current open accounts receivable for the activity's TPC Program. Reason codes 2 through 7 represent invalid denials by insurance companies and require follow up action by the MTF. The subtotal for items 1 through 7 in Part II must equal the amount reported in Part I, item 4(11) of the report.

Reason Codes 8 through 16 represent valid amounts denied by third party payers. No follow-up action is required for claims closed because of reasons indicated in items 8 through 16. The subtotal for items 8 though 16 must equal the amount reported in item 4(7) in Part I of this report.

17. Date of Report: Enter the date the report was prepared at the top of the report, to the right of the words, "Part I".

THIRD PARTY COLLECTION PROGRAM - AGING SCHEDULE

REPORT CONTROL SYMBOL: DD-HA(Q)1855

1. QUARTER ENDING (MMMYY): MAR93

2. REPORTING ACTIVITY: 123rd General Hospital, Knoxville, KY

3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NUMBER: 0985

4. UNPAID ACCOUNTS RECEIVABLE (Use additional sheets as necessary)

Date of Report: 04/03/93

a. UNPAID CLAIMS

b. DOLLAR AMOUNTS REMAINING UNCOLLECTED BY PERIOD

(1) INSURANCE COMPANY	(2) FISCAL YEAR	(3) TOTAL NO. OF CLAIMS	(4) 1-30 DAYS	(5) 31-60 DAYS	(6) 61-90 DAYS	(7) 91-180 DAYS	(8) 181-270 DAYS	(9) 271-360 DAYS	(10) OVER 360 DAYS	(11) TOTAL UNCOLLECTED
Beneficiary	93	817	49,126.26	17,997.39	423.59	0	0	0	0	67,547.24
	92	42	0	0	9,712.39	1,933.35	3,017.56	4,658.07	0	19,321.37
	91	22	0	0	0	0	0	0	4,501.75	4,501.75
Corporate	93	361	12,692.30	4,319.73	14,284.71	0	0	0	0	31,296.74
	92	0	0	0	0	0	0	0	0	0
	91	0	0	0	0	0	0	0	0	0
Country Life	93	381	6,017.56	25,919.62	4,285.45	0	0	0	0	35,222.63
	92	12	0	0	2,398.12	2,573.36	2,186.92	0	0	7,158.40
	91	0	0	0	0	0	0	0	0	0
Metropolis	93	81	0	5,183.24	1,714.16	0	0	0	0	6,897.40
	92	11	0	0	2,479.10	1,715.39	0	0	3,122.03	7,316.52
	91	0	0	0	0	0	0	0	0	0
Physicians Support	93	213	11,423.07	362.87	2,284.99	0	0	0	0	14,070.93
	92	12	0	0	2,743.88	3,431.15	0	2,329.04	0	8,504.07
	91	0	0	0	0	0	0	0	0	0
Post Life	93	119	4,877.48	1,814.37	719.94	0	0	0	0	7,411.79
	92	0	0	0	0	0	0	0	0	0
	91	0	0	0	0	0	0	0	0	0
Safe Corp	93	210	10,685.38	0	5,759.59	0	0	0	0	16,444.97
	92	0	0	0	0	0	0	0	0	0
	91	0	0	0	0	0	0	0	0	0
Security General	93	172	9,754.95	0	5,183.64	0	0	0	0	14,938.59
	92	0	0	0	0	0	0	0	0	0
	91	0	0	0	0	0	0	0	0	0
State Life & Casualty	93	205	11,345.03	4,401.91	12,511.68	0	0	0	0	28,258.62
	92	0	0	0	0	0	0	0	0	0
	91	17	0	0	0	0	0	0	5,974.95	5,974.95
Walgreen	93	60	0	0	6,236.12	0	0	0	0	6,236.12
	92	6	0	0	686.23	0	2,186.92	0	1,865.09	4,738.24
	91	20	0	0	0	0	0	0	6,249.57	6,249.57
c. PAGE TOTAL/GRAND TOTAL	93	2619	114,922.05	59,999.13	53,403.87	0	0	0	0	228,325.03
	92	83	0	0	18,019.72	9,653.25	7,391.40	6,987.11	4,987.12	47,038.60
	91	59	0	0	0	0	0	0	16,726.27	16,726.27

DD Form 2571, FEB 91

INSTRUCTIONS FOR COMPLETING DD FORM 2571, "THIRD PARTY COLLECTION PROGRAM - AGING SCHEDULE,"

Purpose: This report reflects how aggressively MTFs are pursuing collection of accounts receivable resulting from the TPC Program and identifies the specific third party payers that are indebted to the United States. In particular, this report shall identify those payers with a significant history of delinquency that may be candidates for legal action. Report Control Symbol DD-HA(Q) 1855 is assigned. The Aging Schedule shall reflect the sum totals for both inpatient and outpatient encounters. This report excludes active duty and Third Party Liability encounters.

Note: The total amount reported as uncollected in this report shall equal the sum of the amounts reported in Part I, item 4(11) ($ Amount Remaining Uncollected (6)-((7)+(8)+(9)+(10)) of both the inpatient and outpatient DD Form 2570). An automated version of the inpatient report has been developed within the AQCESS MSA module. A summary report for inpatient that consolidates the results of all the Service's MTFs shall be prepared by each Service.

Instructions:

1. Quarter Ending (MMMYY): Enter the last month of the quarter and the FY of the reporting period. For the cumulative report, enter "CUM" after the month and year.

2. Reporting Activity: Enter the reporting MTF or the branch of Service and reporting office if a consolidated report.

3. Defense Medical Information System (DMIS) ID Number: Self-explanatory.

4. Unpaid Accounts Receivable:

a. Unpaid Claims: Enter:

(1) Insurance companies with outstanding accounts receivable balances in descending order based on total amount owed.

(2) The FYs being reported (report the current and two prior FYs as applicable for each insurance company with outstanding billings).

(3) The number of claims made to the particular third party payer. Item 4a(3) Total/Grand Total by fiscal year must match Part I, item 4(3) minus item 4(4) on the inpatient report plus Part I, item 4(3) minus item 4(4) on the outpatient report by fiscal year on the DD 2570.

b. Dollar Amounts Remaining Uncollected by Period: Classify the amounts owed by each third party payer in the appropriate aging categories (items 4 through 10). The age of

the account is measured from the date of billing by the MTF to the end of the reporting period. Separately report amounts billed for the current year and two PYs.

c. Page Total/Grand Total: If multiple pages are necessary, enter the subtotal for the page. If the final page of the report, enter the Grand Total for columns 3 through 11 for each FY being reported (current year and two PYs). The grand total amount reported in column 11 for each FY shall equal the sum of Part I, item 4(11) ($ Amount Remaining Uncollected (6)-((7)+(8)+(9)+(10)) on both the inpatient and outpatient DD Form 2570).

5. Date of Report: Enter the date the report was prepared at the top of the report to the right of item 4, "Unpaid Accounts Receivable".

THIRD PARTY COLLECTION PROGRAM - COLLECTION SOURCE ANALYSIS

REPORT CONTROL SYMBOL: DD-HA(Q)1906

SECTION I

1. QUARTER ENDING (YYMMDD)	2. REPORTING MEDICAL TREATMENT FACILITY	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NUMBER	4. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville, KY	0985	930403

PART A - INPATIENT

PATIENT CATEGORY a.	INPATIENT DISPOSITIONS b.	OBDS c.	ICU OBDS d.	DOLLARS BILLED e.	AMOUNT COLLECTED f.
5. ACTIVE DUTY	[			NO ENTRY	AT THIS TIME
6. DEPENDENT OF ACTIVE DUTY	194	885	34	18,836	7,747.99
7. RETIRED	746	4,991	2,956	101,442	59,441.65
8. DEPENDENT OF RETIRED	627	3,698	1, 710	70,898	49,877.72
9. DEPENDENT OF DECEASED	79	541	28	10,699	3,510.81
10. OTHER	9	43	0	3,890	484.25
11. TOTALS *(See Note 1)*	1,655	10,158	4,728	205,765	121,062.42

PART B - OUTPATIENT

PATIENT CATEGORY a.	VISITS b	DOLLARS BILLED c.	AMOUNT COLLECTED d.
12. ACTIVE DUTY	[	NO ENTRY AT	THIS TIME
13. DEPENDENT OF ACTIVE DUTY	739	77,000	20,731.68
14. RETIRED	996	101,800	27,260.18
15. DEPENDENT OF RETIRED	434	45,000	13,053.27
16. DEPENDENT OF DECEASED	420	44,000	10,593.87
17. OTHER	0	0	0
18. TOTALS	2,589	267,800	71,639.00

Note 1: Total inpatient dispositions in Section I, Part A, column b. may not equal total number of patients in Section II, Part A, column c.

SECTION II - PART A - INPATIENT

19. QUARTER ENDING (YYMMDD)	20. REPORTING ACTIVITY	21. DMIS ID NUMBER	22. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville, KY	0985	930403

MEPRS CODE a.	CLINICAL SERVICE b.	NUMBER OF PATIENTS c.	OBDS d.	DOLLARS BILLED e.
AAA	Internal Medicine	339	1,216	24,631
AAB	Cardiology	176	599	12,133
AAC/DJC	Coronary Care	93	2,465	47,816
AAD	Dermatology	63	176	3,565
AAE	Endocrinology	6	4	81
AAF	Gastroenterology	2	27	546
AAG	Hematology	10	77	1,559
AAH/DJA	Intensive Care (Medical)	95	1,948	39,459
AAI	Nephrology	5	7	141
AAJ	Neurology	20	55	1,114
AAK	Oncology	41	214	4,334
AAL	Pulmonary/Upper Respiratory Disease	8	8	769
AAM	Rheumatology	2	4	81
AAN	Physical Medicine	0	0	0
AAO	Clinical Immunology	0	0	0
AAP	HIV III (AIDS) Referral	1	2	102
AAQ	Bone Marrow Transplant	0	0	0
AAR	Infectious Disease	1	1	119
AAS	Allergy	0	0	0
AAZ	Medical Care Not Elsewhere Classified (N.E.C.)	4	8	162
ABA	General Surgery	330	821	16,630
ABB	Cardiovascular and Thoracic Surgery	28	133	2,694
ABC/DJB	Intensive Care (Surgery)	65	281	5,692
ABD	Neurosurgery	18	114	2,309
ABE	Ophthalmology	58	85	1,721
ABF	Oral Surgery	11	36	729

SECTION II - PART A - INPATIENT *(Continued)*

19. QUARTER ENDING (YYMMDD)	20. REPORTING ACTIVITY	21. DMIS ID NUMBER	22. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville, KY	0985	930403

MEPRS CODE a.	CLINICAL SERVICE b.	NUMBER OF PATIENTS c.	OBDS d.	DOLLARS BILLED e.
ABG	Otolaryngology	53	134	2,714
ABI	Plastic Surgery	19	59	2,945
ABH	Pediatric Surgery	2	3	61
ABJ	Proctology	2	4	102
ABK	Urology	99	254	5,145
ABL	Organ Transplant	5	13	263
ABM	Burn Unit	0	0	0
ABN	Peripheral Vascular Surgery	9	9	182
ABZ	Surgical Care Not Elsewhere Classified (N.E.C.)	55	159	3,221
ACA	Gynecology	124	303	6,382
ACB	Obstetrics	44	174	3,524
ADA	Pediatrics	31	79	1,600
ADB	Nursery	1	6	121
ADC/DJD	Neonatal Intensive Care Unit (ICU)	3	34	689
DJE	Pediatric Intensive Care			
ADD	Adolescent Pediatrics	0	0	0
ADZ	Pediatric Care Not Elsewhere Classified (N.E.C.)	2	8	162
AEA	Orthopedics	99	376	7,616
AEB	Podiatry	54	87	1,762
AEC	Hand Surgery	13	23	466
AFA	Psychiatrics	8	14	283
AFB	Substance Abuse Rehabilitation	10	13	217
AGA	Family Practice Medicine	9	13	263
AGB	Family Practice Surgery	2	5	101
AGC	Family Practice Obstetrics	7	47	952

Note 1: Total inpatient dispositions in Section I, Part A, column b may not equal total number of patients in Section II, Part A, column c.

SECTION II - PART A - INPATIENT *(Continued)*

19. QUARTER ENDING (YYMMDD)	20. REPORTING ACTIVITY	21. DMIS ID NUMBER	22. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville, KY 0985		930403

MEPRS CODE a.	CLINICAL SERVICE b.	NUMBER OF PATIENTS c.	OBDS d.	DOLLARS BILLED e.
AGD	Family Practice Pediatrics	2	47	344
AGE	Family Practice Gynecology	1	7	142
AGF	Family Practice Psychiatry	0	0	0
AGG	Family Practice Orthopedics	1	6	121
AGH	Family Practice Nursery	0	0	0
	INPATIENT TOTAL *(See Note 1)*	2,032	10,158	205,765

Note 1: Total inpatient dispositions in Section I, Part A, column b. may not equal total number of patients in Section II, Part A, column c.

23. REMARKS

SAMPLE

SECTION II - PART B - OUTPATIENT

19. QUARTER ENDING (YYMMDD)	20. REPORTING ACTIVITY	21. DMIS ID NUMBER	22. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville, KY	0985	930403

MEPRS CODE a.	OUTPATIENT CLINIC b.	VISITS c.	DOLLARS BILLED d.
BAA	Internal Medicine Clinic	447	44,700
BAB	Allergy Clinic	231	23,100
BAC	Cardiology Clinic	123	12,300
BAE	Diabetic Clinic	3	300
BAF	Endocrinology (Metabolism) Clinic	7	700
BAG	Gastroenterology Clinic	80	8,000
BAH	Hematology Clinic	13	1,300
BAI	Hypertension Clinic	126	12,600
BAJ	Nephrology Clinic	7	700
BAK	Neurology Clinic	27	2,700
BAL	Nutrition Clinic	54	5,400
BAM	Oncology Clinic	11	1,100
BAN	Pulmonary Disease Clinic	2	200
BAO	Rheumatology Clinic	0	0
BAP	Dermatology Clinic	0	0
BAQ	Infectious Disease Clinic	1	100
BAR	Physical Medicine Clinic	0	0
BAZ	Medical Clinics Not Elsewhere Classified (N.E.C.)	2	200
BBA	General Surgery Clinic	435	43,500
BBB	Cardiovascular and Thoracic Surgery Clinic	1	100
BBC	Neurosurgery Clinic	5	500
BBD	Ophthalmology Clinic	36	3,600
BBE	Organ Transplant Clinic	0	0
BBF	Otolaryngology Clinic	15	1,500
BBG	Plastic Surgery Clinic	24	2,400
BBH	Proctology Clinic	85	8,500

SECTION II - PART B - OUTPATIENT *(Continued)*

19. QUARTER ENDING (YYMMDD)	20. REPORTING ACTIVITY	21. DMIS ID NUMBER	22. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville, KY	0985	930403

MEPRS CODE a.	OUTPATIENT CLINIC b.	VISITS c.	DOLLARS BILLED d.
3BI	Urology Clinic	77	7,700
BBJ	Pediatric Surgery Clinic	70	7,000
BBZ	Surgical Clinics Not Elsewhere Classified	15	1,500
BCA	Family Planning Clinic	130	13,000
BCB	Gynecology Clinic	25	2,500
BCC	Obstetrics Clinic	72	7,200
BDA	Pediatric Clinic	94	9,400
BDB	Adolescent Clinic	48	4,800
BDC	Well Baby Clinic	25	2,500
BDZ	Pediatric Clinics Not Elsewhere Classified (N.E.C.)	1	100
BEA	Orthopedics Clinic	26	2,600
BEB	Cast Clinic	17	1,700
BEC	Hand Surgery Clinic	13	1,300
BEE	Orthotic Laboratory	12	1,200
BEF	Podiatry Clinic	24	2,400
BFA	Psychiatry Clinic	12	1,200
BFB	Psychology Clinic	10	1,000
BFC	Child Guidance Clinic	23	2,300
BFD	Mental Health Clinic	0	0
BFE	Social Work Clinic	9	900
BFF	Substance Abuse Rehabilitation	20	2,000
BGA	Family Practice Clinics	18	1,800
BHA	Primary Care Clinics	90	9,000
BHB	Medical Examination Clinic	8	800
BHC	Optometry Clinic	5	500
BHD	Audiology Clinic	16	1,600

SECTION II - PART B - OUTPATIENT *(Continued)*

19. QUARTER ENDING (YYMMDD)	20. REPORTING ACTIVITY	21. DMIS ID NUMBER	22. DATE OF REPORT (YYMMDD)
930331	123rd General Hospital, Knoxville,	KY 0985	930403

MEPRS CODE a.	OUTPATIENT CLINIC b.	VISITS c.	DOLLARS BILLED d.
BHE	Speech Pathology Clinic	3	300
BHF	Community Health Clinic	14	1,400
BHG	Occupational Health Clinic	5	500
BHH	PRIMUS / NAVCARE Clinic	1	100
BHI	Immediate Care Clinic	27	2,700
BIA	Emergency Medical Clinic	33	3,300
BJA	Flight Medicine Clinic	0	0
BKA	Underseas Medicine Clinic	0	0
BLA	Physical Therapy Clinic		
BLB	Occupational Therapy Clinic		
BLC	Neuromusculoskeletal Screening Clinic		
	AMBULATORY TOTAL	2,678	267,800
	GRAND TOTAL	--------	473,565

23. REMARKS

SAMPLE

INSTRUCTIONS FOR COMPLETING DD FORM 2607, "TPC PROGRAM - COLLECTION SOURCE ANALYSIS," SECTION I

Purpose: This form shall be used as the vehicle to report the source of total charges for inpatient and outpatient TPC beneficiaries by patient category and Medical Expense and Performance Reporting System (MEPRS) code for the current fiscal year. Section one of the report lists total cases, days, intensive care days, charges and amount collected by five major patient categories for inpatients (Part A) and ambulatory care patients (Part B). An automatic version of this report shall be included within the automated medical service accounting system. A Report Control Symbol DD-HA(Q)1905 will be assigned.

Instructions:

1. Quarter Ending (MMMYY): Enter the last month of the quarter and the FY of the reporting period. For the cumulative report enter "CUM" after the month and year. MTFs are only required to report current fiscal year data as data reported for prior years is not expected to change.

2. Reporting Medical Treatment Facility: Enter the reporting MTF or if a consolidated report, enter the branch of Service and reporting office.

3. Defense Medical Information System (DMIS) ID Number: Self-explanatory.

4. Date of Report (YYMMDD): Enter the date the report was prepared.

PART A - INPATIENT

5. Patient Category: Six beneficiary categories and a total line have been established: Active Duty, Dependent of Active Duty, Retired, Dependent of Retired, Dependent of Deceased, and Other.

6. Inpatient Dispositions: Enter the total number of patients, identified as having insurance, which were dispositioned during the period specified for each appropriate patient category. This report excludes active duty and Third Party Liability dispositions. Total inpatient dispositions in Section I, Part A, item 11b, may not equal the total number of patients in Section II, Part A, item c.

7. OBDS: Enter the total number of inpatient days (Occupied Bed Days) for all TPC cases separated by patient category for the period reported. Total OBDS (Section I, Part A,

item 11c) should equal the Total OBDS in Section II, Part A, item d.

8. ICU OBDS: Enter the total number of patient days in one of the intensive care units (ICU) for each patient category. ICU days are a subtotal of OBDS.

9. Dollars Billed: Enter the total amount billed for each patient category during the period reported. The total Dollars Billed (Section I, Part A, item 11e) must match the total Dollars Billed in Section II, Part A, item e. It must also match Total $ Amount Billed/Charges (Part I, item 4(6)a) reported for the current fiscal year on the inpatient version of the DD 2570. It will also equal the sum total of items 11(2)(b)a and 11(4)(b)a in Part I on the DD 2608 for the current fiscal year.

10. Amount Collected: Enter the total amount collected for each patient category during the period reported. The Total Amount Collected (Section I, Part A, item 11f) on the inpatient report must match the $ Amount Collected Current FY (Part I, item 4(10)a) reported on the inpatient version of the DD Form 2570. It must also match the sum total of items 11(2)(c)a and 11(4)(c)a in Part I on the DD 2608 for the current fiscal year.

PART B - OUTPATIENT

11. Patient Category: Six beneficiary categories and a total line have been established: Active Duty, Dependent of Active Duty, Retired, Dependent of Retired, Dependent of Deceased, and Other.

12. Visits: Enter the total number of outpatient visits for each patient category during the period specified. Multiple outpatient visits on the same day to different clinics will result in one charge for each clinic visit. Multiple visits on the same day to the same clinic will only have one charge. The Total Visits (Section I, Part B, item 18b) should equal Total Visits (Section II, Part B, item c).

13. Dollars Billed: Enter the total amount billed for each patient category during the period reported. The Total Dollars Billed (Section I, Part B, item 18c) should equal the Total Dollars Billed in Section II, Part B, item d. It must also match the Total $ Amount Billed/Charges (Part I, item 4(6)a) reported for the current fiscal year on the outpatient version of the DD Form 2570. It will also equal the sum total of items 18(2)(b)a and 18(4)(b)a in Part II on the DD 2608 for the current fiscal year.

14. Amount Collected: Enter the total amount collected for each patient category during the period reported. The Total Amount Collected (Section I, Part B, item 18d) on the outpatient

report must match the $ Amount Collected Current FY (Part I, item 4(10)a) reported on the outpatient version of the DD Form 2570. It must also match the sum total of items 18(2)(c)a and 18(4)(c)a in Part II on the DD 2608 for the current fiscal year.

INSTRUCTIONS FOR COMPLETING DD FORM 2607, "THIRD PARTY COLLECTION PROGRAM - COLLECTION SOURCE ANALYSIS," SECTION II

Purpose: This form shall be used as the vehicle to report the source of charges for inpatient and outpatient TPC beneficiaries by patient category and MEPRS code for the current fiscal year. Section two reports the information by clinical service as identified by the third level MEPRS code. An automatic version of this report shall be included within the automated medical service accounting system. A Report Control Symbol DD-HA(Q)1905 will be assigned.

Instructions:

1. Quarter Ending (MMMYY): Enter the last month of the quarter and the FY of the reporting period. For the cumulative report enter, "CUM" after the month and year. MTFs are only required to report current fiscal year data as data reported for prior years is not expected to change.

2. Reporting Activity: Enter the reporting MTF or if a consolidated report, enter the branch of Service and reporting office.

3. DMIS ID Number: Self-explanatory.

4. Date of Report (YYMMDD): Enter the date the report was prepared.

PART A - INPATIENT

5. MEPRS Code: Information shall be provided for each third level MEPRS inpatient work center.

6. Number of Patients: Enter the total number of patients dispositioned, during the reporting period specified, for each clinical service. Because a patient can transfer from one service to another during a single inpatient stay the total patient count in Inpatient Dispositions (Section I, Part A, item 11b) may not be equal to the Inpatient Total in Section II, Part A, item c.

7. OBDS: Enter the total number of inpatient days for all TPC cases for each clinical service during the reporting period. Total OBDS (Section I, Part A, item 11c) should equal the Total OBDS in Section II, Part A, item d.

8. Dollars Billed: Enter the total amount billed for each clinical service during the reporting period. The total Dollars Billed, Section I, Part A, item 11e should equal the total Dollars Billed, Section II, Part A, item e. It must also match

Part I, item 4(6)a, Total $ Amount Billed/Charges for the current fiscal year on the inpatient version of the DD 2570, and the sum total of items 11(2)(b)a and 11(4)(b)a in Part I on the DD 2608.

PART B - OUTPATIENT

9. Quarter Ending (MMMYY): Enter the last month of the quarter and the FY of the reporting period. For the cumulative report enter, "CUM" after the month and year. MTFs are only required to report current fiscal year data as data reported for prior years is not expected to change.

10. Reporting Activity: Enter the reporting MTF or if a consolidated report, enter the branch of Service and reporting office.

11. DMIS ID Number: Self-explanatory.

12. Date of Report (YYMMDD): Enter the date the report was prepared.

13. MEPRS Code: Information shall be provided for each third level outpatient MEPRS work center.

14. Visits: Enter the total number of outpatient visits for each outpatient clinic during the reporting period. Multiple outpatient visits on the same day to different clinics will result in one count for each clinic visit. Multiple visits on the same day to the same clinic will only count as one visit. The total visits reported in Section II, Part B, item c should equal the total visits reported in Section I, Part B, item 18b.

15. Dollars Billed: Enter the total amount billed for each outpatient visit during the reporting period. The total Dollars Billed reported in Section II, Part B, item d should equal the total Dollars Billed reported in Section I, Part B, item 18c. It must also match Total $ Amount Billed/Charges, Part I, item 4(6)a, on the outpatient version of the DD 2570 for the current fiscal year, and the sum total of items 18(2)(b)a and 18(4)(b)a in Part II on the DD 2608.

THIRD PARTY COLLECTION PROGRAM - INSURANCE TYPE REPORT

PART I - INPATIENT

REPORT CONTROL SYMBOL: DD-HA(Q)1906

1. QUARTER ENDING (YYMMDD)	2. REPORTING MEDICAL TREATMENT FACILITY	3. DEFENSE MEDICAL INFORMATION SYSTEM (DMIS) ID NUMBER	4. DATE OF REPORT (YYMMDD)
MAR93	123rd General Hospital, Knoxville, KY	0985	930403

(1) Patient Category	(2) Medical Care Insurance			(3) No-Fault/Auto Liability Insurance			(4) Medicare Supplemental Insurance			(5) Other Insurance (See Note 2)		
	INPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)	INPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)	INPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)	INPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)
5. ACTIVE DUTY												
a. CURRENT FISCAL YEAR 93	0	0	0	1	1,141	0	0	0	0	0	0	0
b. PRIOR YEAR (PY) 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c. PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
6. DEPENDENT OF ACTIVE DUTY												
a. CURRENT FISCAL YEAR 93	194	18,836	7,747.99	0	0	0	0	0	0	13	1,499.16	1,042.37
b. PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c. PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
7. RETIRED												
a. CURRENT FISCAL YEAR 93	704	93,475	34,831.60	0	0	0	60	7,967	24,610.05	2	301.40	273.03
b. PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c. PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
8. DEPENDENT OF RETIRED												
a. CURRENT FISCAL YEAR 93	613	41,543	34,832.50	0	0	0	32	29,355	15,045.22	3	470.38	417.62
b. PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c. PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
9. DEPENDENT OF DECEASED												
a. CURRENT FISCAL YEAR 93	6	7,231	2,451.23	1	962	0	73	3,468	1,059.58	6	792.20	641.73
b. PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c. PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
10. OTHER												
a. CURRENT FISCAL YEAR 93	11	3,890	484.25	0	0	0	0	0	0	1	140.87	79.14
b. PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c. PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
11. TOTALS												
a. CURRENT FISCAL YEAR 93	1,528	164,975	80,347.57	2	2,103	0	165	40,790	40,714.85	25	3,204.01	2,453.89
b. PY 1 92	4,222	537,328	156,070.09	0	0	0	0	0	0	0	0	0
c. PY 2 91	3,098	234,066	20,011.28	0	0	0	0	0	0	0	0	0

NOTE 1: Dollars shall be matched against and reported for the fiscal year in which the services were rendered

NOTE 2: Includes high-cost services and purchased supplemental services

Note: PY1 and PY2 data may not be available by patient category. If not available report totals only.

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PART II - OUTPATIENT

(1) Patient Category	(2) Medical Care Insurance			(3) No-Fault/Auto Liability Insurance			(4) Medicare Supplemental Insurance			(5) Other Insurance (See Note 2)		
	OUTPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)	OUTPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)	OUTPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)	OUTPATIENT CLAIMS (a)	DOLLARS BILLED (b)	AMOUNT COLLECTED (c)
12. ACTIVE DUTY												
a CURRENT FISCAL YEAR 93	0	0	0	0	0	0	0	0	0	0	0	0
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
13. DEPENDENT OF ACTIVE DUTY												
a CURRENT FISCAL YEAR 93	699	69,900	18,534.74	13	1,300	402.25	71	7,100	2,196.94	53	5,836.44	4,051.70
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
14. RETIRED												
a CURRENT FISCAL YEAR 93	924	92,400	24,534.16	46	4,600	1,334.01	94	9,400	2,726.02	108	12,475.18	9,347.50
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
15. DEPENDENT OF RETIRED												
a CURRENT FISCAL YEAR 93	402	40,200	11,660.78	3	300	87.02	48	4,800	1,392.49	89	11,032.50	7,231.99
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
16. DEPENDENT OF DECEASED												
a CURRENT FISCAL YEAR 93	373	37,300	8,980.71	7	700	168.54	67	6,700	1,613.16	6	610.05	483.52
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
17. OTHER												
a CURRENT FISCAL YEAR 93	0	0	0	0	0	0	0	0	0	0	0	0
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0
18. TOTALS												
a CURRENT FISCAL YEAR 93	2,398	239,800	63,710.39	69	6,900	1,991.82	280	28,000	7,928.61	256	29,954.17	21,114.71
b PY 1 92	0	0	0	0	0	0	0	0	0	0	0	0
c PY 2 91	0	0	0	0	0	0	0	0	0	0	0	0

NOTE 1: Dollars shall be matched against and reported for the fiscal year in which the services were rendered.

NOTE 2: Includes high-cost services and purchased supplemental services.

INSTRUCTIONS FOR COMPLETING DD FORM 2608, "THIRD PARTY COLLECTION PROGRAM - INSURANCE TYPE REPORT," PART I - INPATIENT

Purpose: This form shall be used as the vehicle to report the type of insurance policy billed for inpatient care by patient category for the current and two prior FYs. An automatic version of this report will be included within the automated medical service accounting system. A Report Control Symbol DD-HA(Q)1906 will be assigned.

Instructions:

1. Quarter Ending (MMMYY): Enter the last month of the quarter and the FY of the reporting period. For the cumulative report enter "CUM" after the month and year.

2. Reporting Medical Treatment Facility: Enter the reporting MTF or if a consolidated report, enter the branch of Service and reporting office.

3. Defense Medical Information System (DMIS) ID Number: Self-explanatory.

4. Date of Report (YYMMDD): Enter the date the report was prepared.

5. Patient Category: Six beneficiary categories and a total line have been established: Active Duty, Dependent of Active Duty, Retired, Dependent of Retired, Dependent of Deceased, and Other. This is the only form that includes active duty cases.

6. Inpatient Claims: Enter the total number of claims billed to an insurance company during the period specified for each appropriate patient category and insurance type. The sum total of items 11(2)(a) and 11(4)(a) in Part I must match Part I, item 4(2) on the inpatient version of the DD 2570 for each fiscal year and it must equal Section I, Part A, item 11b on the DD 2607 for the current fiscal year only.

7. Dollars Billed: Enter the total amount billed for inpatient care for each insurance type for the respective patient category and the period specified. The sum total of items 11(2)(b) and 11(4)(b) in Part I must match Part I, item 4(6), Total $ Amount Billed/Charges, on the inpatient version of the DD 2570 for each fiscal year and it must also equal Section I, Part A, item 11e on the DD 2607 for the current fiscal year only.

8. Amount Collected: Enter the total amount collected for inpatient care for each insurance type for the respective patient category and the period specified. The sum total of items 11(2)(c) and 11(4)(c) in Part I must match Part I, item 4(10), $ Amount Collected Current FY, on the inpatient version of the DD 2570 for the current fiscal year and it must also equal Section I, Part A, item 11f on the DD 2607 for the current fiscal year only.

9. Totals, Current FY, PY1, PY2: For each type of insurance category or billing methodology enter the sum totals for "Inpatient Claims", "Dollars Billed", and "Amount Collected" for each of the FYs (Current FY, PY1, PY2) reported.

10. Medical Care Insurance: Billable commercial insurance companies that provide broad payment benefits that cover virtually all expenses connected with hospital and medical care and related services. Does not include active duty or no-fault/auto liability insurance plans which are identified separately, or non-billable insurances such as CHAMPUS.

11. No-Fault/Auto Liability Insurance: An insurance contract providing compensation for health and medical expenses for injuries resulting from operation of a motor vehicle in which the compensation may or may not be premised on who may have been responsible for causing such injury.

12. Medicare Supplemental Insurance (Note 2): Includes billable Medicare supplemental insurance.

13. Other Insurance (Note 3): Includes certain High Cost ancillary services, prescription drugs, or other procedures separately identified. Also includes supplemental care costs billed to an insurance company.

(Dollars shall be matched against and reported for the FY in which the services were rendered.

INSTRUCTIONS FOR COMPLETING DD FORM 2608, "THIRD PARTY COLLECTION PROGRAM - INSURANCE TYPE REPORT PART II - OUTPATIENT"

Purpose: This form shall be used as the vehicle to report the type of insurance policy billed for outpatient care by patient category for the current and two prior FYs. An automatic version of this report will be included within the automated medical service accounting system. A Report Control Symbol DD-HA(Q)1906 will be assigned.

Instructions:

1. Patient Category: Six beneficiary categories and a total line have been established: Active Duty, Dependent of Active Duty, Retired, Dependent of Retired, Dependent of Deceased, and Other.

2. Outpatient Claims: Enter the total number of outpatient claims billed to an insurance company for each appropriate patient category and insurance type during the reporting period. Multiple outpatient visits on the same day to different clinics will result in one count for each clinic visit. Multiple visits on the same day to the same clinic will only count as one. The sum total of items 18(2)(a) and 18(4)a in Part II must equal Part I, item 4(2) on the outpatient version of the DD 2570 for each fiscal year and it must also equal Section I, Part B, item 18b on the DD 2607 for the current fiscal year only.

3. Dollars Billed: Enter the total amount billed for outpatient care for each insurance type for the respective patient category and the period specified. The sum total of items 18(2)(b) and 18(4)(b) in Part II must match Part I, item 4(6) reported on the outpatient version of the DD 2570 for each fiscal year and it must also equal Section I, Part B, item 18c on the DD 2607 for the current fiscal year only.

4. Amount Collected: Enter the total amount collected for outpatient care for each insurance type for the respective patient category and the period specified. The sum total of items 18(2)(c) and 18(5)(c) in Part II must match Part I, item 4(10) reported on the outpatient version of the DD 2570 for the current fiscal year, and it must also equal Section I, Part B, item 18d on the DD 2607 for the current fiscal year.

5. Totals, Current FY, PY1, PY2: For each type of insurance category or billing methodology, enter the sum totals for "Outpatient Claims", "Dollars Billed", and "Amount Collected" for each of the FYs (Current FY, PY1, PY2) reported.

6. Medical Care Insurance: Billable commercial insurance companies that provide broad payment benefits that cover virtually all expenses connected with hospital and medical care and related services. Does not include active duty or no-fault and auto liability insurance plans which are identified separately, or non-billable insurances such as CHAMPUS.

7. No-Fault/Auto Liability Insurance: An insurance contract providing compensation for health and medical expenses for injuries resulting from operation of a motor vehicle in which the compensation may or may not be premised on who may have been responsible for causing such injury.

8. Medicare Supplemental Insurance (Note 2): Includes billable Medicare supplemental insurance.

9. Other Insurance (Note 3): Includes certain High Cost ancillary services, prescription drugs, or other procedures separately identified. Also includes supplemental care costs billed to an insurance company.

(Dollars shall be matched against and reported for the FY in which the services were rendered).

ISSUE DISCUSSION FORMAT

DOD ISSUE #:_____ **PRIORITY A B C**

SERVICE ISSUE #:_____ **Sponsor of Issue:**_____

Command(MTF):_____ **Date of Issue:**_____

Issue/Topic: (One sentence title of the issue or topic)

Decision Needed: (Briefly state what decision needs to be made. Why do we need to talk about this issue?)

Deadline for Decision/Implementation: (When is the latest that a decision can be made and when should implementation be targeted?)

Background: (Provide a brief history of the issue/topic. What has been done in the past? What has occurred that has caused this to be an issue that needs resolution? What will be the impact on the sponsoring activity/service if this issue is not approved? Is this an issue that affects more than one activity and/or more than one service? Provide other amplifying information which will help other work group members understand this issue.)

Recommended Solution: (Briefly explain the solution recommended by the originator of this issue/topic paper. Provide some detail as to how the solution would be implemented and why it is the best solution.)

Other Alternatives Explored: (Provide a brief summary of the various alternatives that were explored as attempts were made to find a solution to the issue. Short descriptions of the principal feasible alternatives are preferred over a lot of detail or explanation of impractical alternatives.)

Recommendation of the Services

SERVICE	AGREE	DISAGREE	AGREE WITH SOME MODIFICATIONS	SIGNATURE OF SERVICE REP
Air Force	_____	_____	_____	_____
Army	_____	_____	_____	_____
Navy	_____	_____	_____	_____

Final Resolution:_____

Resolved By/Date:_____

TPC ISSUE PROCESS

A. INTRODUCTION

Both the DoDI and AQCESS software will be subject to changes, refinements and clarifications over time. A formal issues process is intended to ensure uniformity of interpretation and application by the medical treatment facilities, Services, and OASD(HA). It will contribute to the process of introducing new ideas and applications for incorporation into the DoDI and AQCESS software, as well as for modifying or rescinding procedures.

B. ISSUE IDENTIFICATION

1. Changes

This type of issue encompasses questions about recommendations for changes to the instruction or software based on implementing and operating experience of the program. All issues falling into this category shall be forwarded via respective Military Service command chains to the OASD(HA) for resolution and possible incorporation.

2. Interpretations

This type of issue refers to questions about interpretation of requirements and applications as set forth in the instruction or in the Military Services' implementing documents. Issues falling into this category may be forwarded to the OASD(HA) for resolution, but can usually be resolved at the headquarters level of the respective Military Service. Information copies of such interpretive resolutions shall be forwarded to OASD(HA).

3. Administrative/Other

This type of issue refers to questions about the administration of the system and possible interfaces with other systems, integration of this system and other data requirements, and various other subjects not directly related to system procedures and methodologies. Issues of this kind are normally resolved within the respective Military Service command chains.

C. ISSUE RESOLUTION

The issue resolution should be accomplished at the lowest level possible depending on the impact of the issue or topic. Full consideration must be given to the conclusion in terms of its possible or probable consequences at other medical treatment facilities or Military Departments.

D. RECORDING THE ISSUE

For purposes of uniformity, monitoring, and subsequent auditing, it is important that an accurate and complete record of issues be maintained at each issue resolution level. See the attached format that shall be used to record issues that have been identified. The data elements on the form and their definitions are listed below:

a. DoD Issue #: A unique number that is assigned by OASD(HA) for purposes of reference and control for all issues submitted for resolution and possible inclusion in the instruction or existing software.

b. Service Issue #: A unique number that is assigned by the respective Service headquarters for purposes of reference and control.

c. Command (MTF): State which facility or command submitted the issue.

d. Priority: The priority will be assigned by the Third Party Collection Working Group. "A" priority is considered an emergency, causes a work stoppage, and must be resolved immediately for the program to continue successfully. "B" priority is considered necessary, does not cause a work stoppage, but must be resolved in the near future. "C" priority is for changes that make the program easier, but are not necessary for the program to continue.

e. Sponsor of Issue: The Service headquarters

f. Date of Issue: The date the issue was originally submitted.

g. Issue/Topic: The title of the issue or topic.

h. Decision Needed: Briefly state what decision needs to be made and why.

i. Deadline for the Decision/Implemertation: State when a decision must be made and when implementation should occur.

j. Background: Provide a brief history of the issue/topic so the approval authority will understand the issue. Include what has been done in the past, what has occurred to cause this to be an issue, the impact if not approved, and who the issue affects, i.e. facility, Service, or more than one Service.

k. Recommended Solution: Explain the solution the originator recommended. Include why it is the best solution.

l. Other Alternatives Explored: Provide a brief summary of other alternatives that were explored and why they were not feasible.

m. Recommendation of the Services: The Service representative must check the appropriate block and sign the form.

n. Final Resolution: The approving authority will describe the final resolution and any necessary action, i.e. software changes, etc.

o. Resolved by/Date: State who resolved the issue and the date the issue was resolved.

SUPPLEMENTARY

INFORMATION

DEPARTMENT OF DEFENSE
DIRECTIVES SYSTEM TRANSMITTAL

NUMBER	DATE	DISTRIBUTION
See Below Pen Changes	November 16, 1994	6000 series

ATTACHMENTS

None

ERRATA AD-A272 423

INSTRUCTIONS FOR RECIPIENTS

Pen changes to the following DoD Issuances are authorized:

DoD Issuance Number and Date	Change Number
DoD Directive 6000.2, April 8, 1988 Section H. Heading. Delete "AND IMPLEMENTATION" Lines 1 and 2. Delete "Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days."	Change 1
DoD Directive 6000.6, August 24, 1977 Section E. Heading. Delete "AND IMPLEMENTATION" Paragraph 2. Delete in its entirety.	Change 1
DoD Directive 6000.8, December 6, 1985 Section G. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 3. Delete "Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) within 120 days."	Change 1
DoD Directive 6010.7, August 27, 1975 Section VIII. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 4. Delete "Three copies of proposed implementing regulations shall be forwarded to the Assistant Secretary of Defense (Health Affairs) within 30 days."	Change 5

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, THIS TRANSMITTAL SHOULD BE FILED WITH THE BASIC DOCUMENT

NUMBER	DATE	DEPARTMENT OF DEFENSE
See Below Pen Changes	November 16, 1994	DIRECTIVES SYSTEM TRANSMITTAL

INSTRUCTIONS FOR RECIPIENTS (continued)

DoD Issuance Number and Date	Change Number
DoD Directive 6010.13, February 3, 1986 Section G. Heading. Delete "AND IMPLEMENTATION" Lines 1 and 2. Delete "Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days."	Change 1
DoD Instruction 6010.15, March 10, 1993 Section H. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 3. Delete "Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days."	Change 1
DoD Directive 6010.16, March 8, 1988 Section H. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 6. Delete "The Office of the Armed Forces Medical Examiner shall be established within 120 days of the implementation of this Directive, at which time the procedures for the notification of death shall be in effect. The Director of AFIP shall prepare a tri-Service implementing regulation and shall forward one copy of implementing document to the Assistant Secretary of Defense (Health Affairs) within 6 months."	Change 1
DoD Directive 6015.1, December 12, 1988 Section E. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 3. Delete "Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 90 days."	Change 1
DoD Directive 6015.16, April 15, 1986 Section F. Heading. Delete "AND IMPLEMENTATION" Lines 1 and 2. Delete "Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 60 days."	Change 1
DoD Instruction 6025.15, November 9, 1992 Section H. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 3. Delete "The Military Departments shall forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days."	Change 1

NUMBER	DATE	DEPARTMENT OF DEFENSE
See Below Pen Changes	November 16, 1994	DIRECTIVES SYSTEM TRANSMITTAL

INSTRUCTIONS FOR RECIPIENTS (continued)

DoD Issuance Number and Date	Change Number
DoD Directive 6420.1, December 9, 1982 Section F. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 3. Delete "Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days."	Change 2
DoD Directive 6430.2, June 21, 1984 Section F. Heading. Delete "AND IMPLEMENTATION" Lines 1 through 3. Delete "Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days."	Change 1

EFFECTIVE DATE

The above pen changes are effective immediately. Although the pen changes remove the requirement for DoD Components to issue implementing documents, the DoD issuances are directly applicable to all elements with the Components and the Heads of the DoD Components are responsible for carrying out the DoD guidance.

James L Elmer

JAMES L. ELMER
Director
Correspondence and Directives